Statewide Health Care Task Force

Report—Findings and Recommendations

December 2003

Report - Findings and Recommendations

STATEWIDE HEALTH CARE TASK FORCE

December 2003

Membership

Senator Linda Binder
Co-Chair

Senator Carolyn Allen
Senator Dean Martin
Senator Robert Cannell
Dr. George Burdick
Mr. Terry Cooper
Ms. Nancy Koff

Representative Jim Carruthers
Co-Chair

Representative Deb Gullett
Representative Ted Carpenter
Representative Amanda Aguirre
Mr. Kirk Adams
Sandy Gibson

INTRODUCTION

This report summarizes the efforts of the Statewide Health Care Task Force during the past year. As required by the legislation, this report is being submitted to the Arizona Speaker of the House of Representatives, the Arizona President of the Senate and the Governor for their review and consideration.

Purpose of Task Force

The Task Force, which was established pursuant to Laws 2002, Chapter 265, was charge with the following:

- Continue the efforts of the statewide health care insurance plan task force established by Laws 2000, Chapter 320, Section 1.

Task Force Members

As set forth in the legislation, the Task Force consists of thirteen members:

Two Members of the House Representative Jim Carruthers, Co-chair Representative Amanda Aguirre	**Two Members of the Senate** Senator Linda Binder, Co-Chair Senator Robert Cannell
Chairman of the House Health Committee Representative Deb Gullett	**Chairman of the Senate Health Committee** Senator Carolyn Allen
Chairman of the House Financial Institutions and Insurance Committee Representative Ted Carpenter	**Chairman of the Senate Banking and Insurance Committee** Senator Dean Martin
One Health Care Provider Dr. George Burdick	**Representative from a Consumer Advocacy Group** Terry Cooper
Representative from the Business Community Kirk Adams	**Representative from the University of Arizona** Nancy Koff
Representative from a Health Care Insurance Plan Sandy Gibson	

Pursuant to the legislation, the Task Force is repealed from and after December 31, 2004.

TASK FORCE ACTIVITIES

The Task Force held three meetings during the past year:

July 15, 2003
The first meeting of the Task Force began with introductions, a review of the previous activities of the Task Force and the committee charge. The Task Force created two working groups to study health care infrastructure/self insurance and high-risk pools. There were three presentations given to the Task Force:

- Update on Task Force Activities, the Health Resources and Services Administration (HRSA) Grant, Self-Insurance – Staff
- Update on Arizona Health Care Cost Containment Programs (AHCCCS) – AHCCCS
- FY 2003-2004 Health Budget– Joint Legislative Budget Committee

October 15, 2003
The second meeting of the Task Force began with an update from two working groups. There were two presentations given to the Task Force:

- Update on Working Group Activities – Representative Gullett and Sandy Gibson
- Presentation on Status Health Insurance in Arizona– Department of Insurance

November 6, 2003
The third meeting of the Task Force continued the discussion from the previous meeting on self-insurance. There were four presentations given to the Task Force:

- Update on Health Care Programs – AHCCCS
- Rebuttal on Self Insurance – CIGNA Healthcare
- Update on Self-Insurance – AHCCCS
- Presentation on Long-Term Care Partnership – Stan Hovey

Public Participation
Aside from the scheduled presentations to the Task Force, the public testimony was provided by the following individuals:

Governor's Advisory Council on Aging
Stan Hovey - Retiree
Arizona Silver Haired Legislature

Attachments
Laws 2002, Chapter 265 – Enabling Legislation

July 15, 2003 Meeting
- Agenda
- Minutes
- Committee Charge
- Introduction to AHCCCS
- Health Coverage in Arizona
- Health Coverage in Arizona (Income Based)
- Health Care Budget
- Long Term Care Partnership

October 15, 2003 Meeting
- Agenda
- Minutes
- Briefing on Self-Insurance
- Arizona's Health Insurance Market
- Ranking of Top 25 Insurers – Accident & Health Premiums Written
- Ranking of Top 25 Insurers – All Other Health Care Premiums Written
- 2002 Insurance Market Analysis Survey
- Arizona Accountable Health Plans
- Small Group Premium and Tax Exempt Data from Premium Tax Reports
- Mandatory Health Insurance – Arizona Silver Haired Legislature

November 6, 2003 Meeting
- Agenda
- Minutes
- Overview of AHCCCS
- State Employee Health Insurance Program – CIGNA
- Self-Insurance – Department of Administration
- Long Term Care Partnership

Recommendations
The Task Force has not made any findings or recommendations prior to the submission of this report.

State of Arizona
House of Representatives
Forty-fifth Legislature
Second Regular Session
2002

CHAPTER 265

HOUSE BILL 2286

AN ACT

ESTABLISHING A STATEWIDE HEALTH CARE SYSTEM TASK FORCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Statewide health care system task force

A. The statewide health care system task force is established consisting of the following members:

1. Two members of the house of representatives who are appointed by the speaker of the house of representatives and who are not members of the same political party. The speaker of the house of representatives shall designate one of these members to cochair the task force.

2. The chairman of the house health committee or its successor committee or the chairman's designee.

3. The chairman of the house financial institutions and insurance committee or its successor committee or the chairman's designee.

4. Two members of the senate who are appointed by the president of the senate and who are not members of the same political party. The president of the senate shall designate one of these members to cochair the task force.

5. The chairman or the chairman's designee of the senate health committee or its successor committee.

6. The chairman or the chairman's designee of the senate banking and insurance committee or its successor committee.

7. One health care provider, who is licensed in this state and who is appointed by the governor.

8. One member who represents a consumer advocacy group and who is appointed by the governor.

9. One member who represents the business community and who is appointed by the governor.

10. One member who represents the university of Arizona health science center and who is appointed by the governor.

11. One member who represents a health care insurance plan and who is appointed by the governor.

B. The task force shall:

1. Be guided by the principle that health care should be:

(a) Available and accessible.

(b) Affordable and properly financed.

(c) Provided through a seamless system.

(d) Done in collaboration and in cooperation with the various stakeholders from the public and private sectors.

2. Continue the efforts of the statewide health care insurance plan task force established by Laws 2000, chapter 320, section 1.

C. Task force members are not eligible for compensation or for reimbursement of expenses.

D. On or before November 15 of each year, the statewide health care system task force shall submit any findings and recommendations regarding its proposal for a statewide health care system to the governor, the president of the senate and the speaker of the house of representatives and shall provide a copy of this proposal to the secretary of state and the director of the Arizona state library, archives and public records.

Sec. 2. Delayed repeal

This act is repealed from and after December 31, 2004.

APPROVED BY THE GOVERNOR MAY 21, 2002.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 22, 2002.

ARIZONA STATE LEGISLATURE

Interim Meeting Notice

Open to the Public

Statewide Health Care System Task Force

DATE: **Tuesday, July 15, 2003**

TIME: **1:00 pm**

PLACE: **Senate Appropriations Room 109**

AGENDA

1. Opening Remarks & Introductions
2. Review of Taskforce Activities and Committee Charge – Staff
3. Update on Arizona Health Care Cost Containment programs – AHCCCS
4. FY 2003-2004 Health Budget – Joint Legislative Budget Committee
5. Future Taskforce Activities & Goal Setting – Cochairman
6. Committee Discussion
7. Public Testimony
8. Adjourn

MEMBERS:

Senator Binder – Cochair
Senator Allen
Senator Cannell
Senator Martin

Representative Carruthers – Cochair
Representative Aguirre
Representative Carpenter
Representative Gullett

Kirk D. Adams
Dr. George Burdick
Terry Cooper
Sandy Gibson
Nancy Koff

tm
11/26/2003

People with disabilities may request reasonable accommodations such as interpreters, alternative formats, or assistance with physical accessibility. If you require accommodations, please contact the Chief Clerk's Office at (602) 542-3032, (TDD) 542 6241.

ARIZONA STATE LEGISLATURE
Forty-sixth Legislature – First Regular Session

STATEWIDE HEALTH CARE TASK FORCE

Minutes of Meeting
Tuesday, July 15, 2003
Senate Appropriations Room 109 -- 1:00 p.m.

Chairman Binder called the meeting to order at 1:06 p.m. and attendance was noted by the secretary.

Members Present

Senator Allen
Senator Cannell
Senator Martin
Senator Binder, Cochair

Representative Aguirre
Representative Carpenter
Representative Gullett
Representative Carruthers, Cochair

Kirk D. Adams
Dr. George Burdick
Sandy Gibson
Nancy Koff

Members Absent

Terry Cooper

Speakers Present

Pete Wertheim, House Majority Research Analyst, Health Committee
C. J. Hindman, Chief Medical Officer/Deputy Director/Interim Acting Director, Arizona Health Care Cost Containment System (AHCCCS)
Tim Sweeney, Fiscal Analyst, Joint Legislative Budget Committee
Barry Gold, Executive Director, Governor's Advisory Council on Aging
Stan Hovey, representing himself

Opening Remarks and Introductions

At the request of Chairman Binder, the Members introduced themselves.

Review of Task Force Activities and Committee Charge

Pete Wertheim, House Majority Research Analyst, Health Committee, related that the former Statewide Health Care Insurance Plan Task Force obtained a grant from the Health Resources Service Administration (HRSA) for $1.16 million to conduct a study, with the assistance of the Arizona Health Care Cost Containment System (AHCCCS) and consultants, on problems

associated with the uninsured. About $10,000 remains from the grant for future projects and reports are available on the AHCCCS web site. Summaries can also be provided to the Members. The original Task Force was repealed in December 2002 and continued for two more years as the Statewide Health Care System Task Force. Only two meetings were held in 2002 due to the election and changes at the Legislature, with the main focus on self-insurance, which was shelved. (For Committee charge, see Attachment 1).

Mr. Wertheim advised Senator Allen that in relation to self-insurance, the Task Force leaned toward contracting service delivery through health care plans, but taking over administration and risk factors.

Senator Martin related that the self-insured program had to be set up by October 2003 or 2004, but it became evident that the date would not be met. The problem was that savings resulted from claims that would not be paid in a three-month lag during the change in administration, which is not really a saving, because claims would be paid as soon as the paperwork is processed. Another major problem related to protecting the reserve. He indicated that he spoke to Betsy Bayless, Director of the Arizona Department of Administration (ADOA), who indicated that ADOA is still working toward self-insurance, but with no specific deadline.

Senator Cannell remarked that based on the information provided, the Members reached the conclusion that self-insurance is definitely advantageous. The state would have more control over the program that is developed, behaviors that could be emphasized, etc., but it must be done right. Many people in ADOA are very knowledgeable and he would like to encourage them to continue. He stated that $60 million to $80 million is needed as a reserve and some method is necessary to protect the funds, but self-insurance could improve the quality of health insurance for state employees.

Mr. Carpenter related that he is a representative of the Deer Valley School District and a member of the board that oversees an insurance program for three school districts. The reserve is protected because it is kept out of the hands of the board, but what cannot be protected is the money the board sends to the Insurance Committee in order to fund the reserve. Some protections must be built into the system so that cannot be tampered with, but he has yet to see anything that is foolproof and would keep the funds out of the hands of the Legislature.

Dr. Burdick commented that self-insurance is utilized across the country in most states, and there are many advantages, particularly in the quality of care, which state employees deserve.

In response to a query by Senator Allen about programs in other states, Mr. Wertheim advised that many of the studies commissioned by the previous Task Force contain data on other states.

Ms. Gibson stated that self-insurance is used by many large employers so the definition is not necessarily constrained to coverage for the state, and a variety of administrators work with self-funding plans. A multitude of arrangements is available so the state would not necessarily have to take on every aspect. She agreed that initially the primary savings is from the claim lag, but submitted that there is also a savings in self-funded models because the state or entity that is self-funded assumes the risk, and therefore, pays less charges typically assessed by carriers. There are some reductions to cost through the way carriers develop a premium rate for a self-funded arrangement or an insured arrangement. She added that during one of the meetings a consultant

showed how the reserve is developed. It does not need to be funded immediately, but by paying expected payments routinely and not allowing the payments to be reduced. She agreed that protecting the reserve was the major challenge.

Senator Binder pointed out that Mr. Carruthers was President of Western College in a former life where a self-insurance plan worked very well. Mr. Carruthers agreed, adding that many programs can be studied to develop the infrastructure and model, which is only part of the puzzle because of the necessity to intermix with AHCCCS, etc.

Ms. Gibson advised Senator Allen that over time, as the reserves build up, the unpaid claim liability is paid, which must be evaluated each month and a new amount established. Also, many large employer groups purchase some form of stop loss, or reinsurance, so in the event any individual incurs claim expenses beyond a certain dollar limit, or the entire plan exceeded a claims dollar limit, coverage could be purchased to reimburse the state. She recalled that the self-funded arrangement the state looked at included a form of stop loss, or reinsurance.

Senator Martin verified that the infrastructure had to be in place by October 2003 so the Members were wise to delay. He indicated that he formerly set up self-insured programs for private sector businesses and many choices are available. The reserve system could be set up slowly and built over time. He indicated that reviewing how the reserve is protected in the State Compensation Fund might be helpful because the system is similar. He related that executives at a major insurance company practicing in the state for other types of insurance than health hired an actuarial firm to conduct an analysis of the health care market to determine whether or not to expand in Arizona. It was determined that the top three risks in Arizona are proximity to the border, the high number of uninsured people, and the lack of a risk pool, so no expansion was recommended. Nothing can be done about proximity to the border, but a risk pool, from an actuarial standpoint, is very high on the list of items to accomplish, although money is always an issue.

Update on AHCCCS Programs

C. J. Hindman, Chief Medical Officer/Deputy Director/Interim Acting Director, Arizona Health Care Cost Containment System (AHCCCS), briefly reviewed a handout regarding AHCCCS programs (Attachment 2). He related to Mr. Carruthers that he believes AHCCCS receives so much national recognition because of the partnerships developed with the private sector health care delivery system, the fact that AHCCCS recognized that there are many different ways to provide managed care, and AHCCCS has been very fortunate in avoiding bad consequences experienced by other managed care models, such as withholdings from providers that have to pay losses. Arizona providers are not placed at very much risk.

Mr. Burdick opined that administration at AHCCCS has been outstanding except for the initial two years. He is concerned, though, about the for-profit sector entering into the managed care system because, in traveling around the state and talking to physicians, most problems involved for-profit companies that start using the same techniques that are used otherwise. Another problem is increasing coverage. He added that physicians in general are very supportive of AHCCCS, which is not true in other states.

Dr. Hindman provided the following information in response to questions posed by the Members:

- There are fewer female AHCCCS members than male because the eligibility categories were primarily designed to provide health care for women and children. Most of the adult males are disabled, aged, or blind.
- The Kids Care Parents program was capped at 21,000 individuals, and as of today, there are about 10,000 on the program, which is a very small portion of the total number. The program went into effect in January 2003, so it was just beginning. During budget negotiations of the past session, KidsCare was funded, but Kids Care Parents was only funded through June 30, 2004.
- HealthCare Group is still in place. The program had some rocky times and evolved into essentially a risk pool by virtue of evolution. In 1996/1997, the Legislature provided a subsidy to cover the risk because the premiums did not. During the 2002 session, however, the Legislature requested that AHCCCS make the program self-sustaining since future annual subsidies cannot be guaranteed. Effective February 2003, actuaries reviewed the rate structure for the HealthCare Group product, and consequently, initiated changes to the benefits and new premiums. Current membership is about 11,400, primarily in Maricopa, Pima, and Cochise counties, with two health plans participating. Part of the plan to make the program self-sustaining is to develop a marketing approach to expand awareness of the product and an option for small businesses and political subgroups, such as counties or school districts. Presentations are also being made to potential additional health plans about participation. It is not a capped program.
- Medicaid Cost Sharing relates to individuals eligible for Medicare by virtue of age or disability who also meet the criteria of financial eligibility for Medicaid and are called dual eligible.

Dr. Hindman reviewed handouts entitled *Health Coverage in Arizona* (Attachment 3) and *Health Coverage in Arizona (Income Based)* (Attachment 4). He conveyed the following information in response to questions posed by the Members:

- 16 percent of Arizona citizens are uninsured.
- The issue of ensuring that the Arizona Long-Term Care System (ALTCS) will be able to meet the challenges of the aging population was identified and included in AHCCCS' strategic plan. An outline was created on how to proceed, including obtaining grant dollars to hire expertise to evaluate, analyze, and develop a plan.
- The chronically ill category in the Premium Sharing program was capped at 200 individuals at any one time. Individuals were notified about the pending wind down and provided with references to resources that may be able to help, such as federally qualified community health centers. Other community resources may help depending on the diagnosis, certain foundations will provide help, and if a person shows there is no other resource for particular expensive medications, even pharmaceutical companies will work out individual programs through physicians.

FY 2003-2004 Health Budget

Tim Sweeney, Budget Analyst, Joint Legislative Budget Committee, gave an overview of budget figures for AHCCCS (Attachment 5).

Dr. Hindman related to Mrs. Gullett that a state plan amendment for redetermination was submitted to the Centers for Medicare and Medicaid Services (CMS), which conducted a site visit a few weeks ago. A final and formal decision on approval is expected soon. He is not aware of any reason the amendment would not be approved, but hesitates to speculate what the decision might be.

Mr. Cannell asked how money from the federal government provided for ALTCS through the Bush tax cut will impact the counties. Mr. Sweeney replied that counties will experience different impacts, but in total, the county contribution will be lower than in 2003 because of the federal savings.

Mr. Sweeney reviewed budget information relating to the Arizona Department of Health Services (ADHS). He advised Senator Binder that tobacco tax revenues are rebounding compared to a few months ago. The original forecast for 2003 will still not be met, but caseload estimates for the budget as of the 1st Special Session for 2003 are also low by about the same amount. The forecast for 2004 has not been changed because it is not clear if collections are rebounding to the point of starting the natural decline of tobacco tax collections, but that should become apparent in the next few months.

Mr. Sweeney presented budget figures relating to the Arizona Department of Economic Security (DES) (Attachment 5).

Future Task Force Activities and Goal Setting

Mr. Carruthers stated that Working Groups are needed relating to infrastructure and risk pools. The following Members were appointed/volunteered:

Infrastructure	Risk Pools
Sandy Gibson	Senator Cannell
Senator Allen	Senator Martin
Representative Gullett	Representative Aguirre
	Representative Carpenter
	Dr. Burdick
	Sandy Gibson

Mr. Carruthers asked the Members to review the principles and goals of the Task Force to determine if changes are necessary.

Mr. Carpenter related that he recently attended an event in Virginia with the National Conference of Insurance Legislators (NCOIL). NCOIL has an Internet site containing information from individual state programs, as well as a Committee on Health Insurance, which might be helpful.

Chairman Binder thanked everyone for attending. She stated that affordable, available health care is probably one of the most important issues the state faces and certainly the one issue she hears about most from constituents. Considering the cuts made in the budget and decreases that might have to be made in the future, it is very important to keep "an eye on the ball."

Public Testimony

Barry Gold, Executive Director, Governor's Advisory Council on Aging, stated that the Interagency Council on Long-Term Care is reviewing many different items relating to long-term care, including health care. At the last meeting, legislators still needed to be appointed because previous legislators are no longer in the Legislature, if anyone is interested in volunteering. He stated that he was fortunate to be able to attend the Arizona Town Hall this year where the topic was health care and aging later life decisions. Some of the recommendations in the report and background information from the University of Arizona may be very helpful to the Task Force. Normally, the reports are sold for $10, but considering that the major emphasis of the Town Hall is to influence public policy, the material could probably be sent to the Members at no charge.

Stan Hovey, representing himself, referred to the "crunch time" that is approaching with the ALTCS program and population. He advised that a program called the Long Term Care Partnership Program was developed in the early 1990s and is basically a partnership between private long-term care insurers and the state Medicaid program to pay for long-term care services (Attachment 6). It is currently operating in California, Connecticut, Indiana, and New York. He encouraged the Members to place the program on the agenda as a study issue since it could benefit the citizens and state.

Senator Cannell stated that the Task Force needs to encourage training programs in Arizona, coordination of care, and training of physicians and other health care providers that will go to underserved areas.

After some discussion, the Members agreed to meet on September 23, 2003.

Without objection, the meeting adjourned at 2:38 p.m.

Linda Taylor

Linda Taylor, Committee Secretary
July 23, 2003

(Original minutes, attachments, and tape are on file in the Office of the Chief Clerk.)

Statewide Health Care System Task Force

(Formerly Statewide Health Care Insurance Plan Task Force)

The Statewide Health Care Insurance Plan Task Force (Task Force) established pursuant to Laws 2000, Chapter 320 was charged with the task of developing an affordable and accessible health care insurance plan for all Arizonans. As part of this effort the Task Force was also required to undertake the following activities:

- Identify and assess potential insurance risk pools among residents of this State.
- Study and recommend timely and efficient reimbursement methods.
- Determine benefit levels.
- Review current national, state and local public health care plans.
- Review and analyze the role of state agencies and political subdivisions under a statewide health care insurance plan.
- Analyze health care insurance factors that vary among urban and rural areas and recommend ways in which these factors could be streamlined.
- Study and recommend ways to treat rural and urban areas in an equitable manner.
- Identify the various sources of monies to fund a statewide health care insurance plan.
- Explore alternatives that may be used to initiate a health care plan that would be available to and affordable for residents in both rural and urban areas.

Guiding Principles

- Health care, especially basic benefits, should be available and accessible
- Health care should be affordable and properly financed
- Health care should be provided through a seamless system, offering the highest quality care.
- Health care should be done in collaboration and in cooperation with the various stakeholders both public and private sector and it should foster competition.

Final Recommendations

Recommendation 1: Adoption of Proposed Enabling Legislation

The Task Force formally voted to adopt proposed enabling legislation that establishes a more defined framework within which the State can continue its efforts to develop a seamless health care system in Arizona through the implementation of various strategies over the next two to three years.

Recommendation 2: Support of HealthCare Group Changes

While the current economic climate in Arizona does not lend itself to the implementation of new programs, the Task Force felt that it was important to try and maintain those programs that have proven to play an effective role in making health care coverage accessible and affordable to Arizonans. To that end the Task Force supported the continuation of the HealthCare Group program and formally adopted a series of proposed changes to the program.

Statewide Health Care System Task Force
Laws 2002, Chapter 265 continues the efforts of the Statewide Health Care Insurance Plan Task Force as the Statewide Health Care System Task with modifications to its membership and committee charge to include all health care issues. The Task force was extended until December 31, 2004 and is guided by the principle that health care should be:

- Available and accessible.
- Affordable and properly financed.
- Provided through a seamless system.
- Done in collaboration and in cooperation with the various stakeholders from the public and private sectors.

In addition, the Task Force is charged with continuing the efforts of the previous Task Force.

Guiding Principles
During its meetings in 2002, the Task Force and discussed the following issues to work on in the future:

- Provide a continuum of health care services and information.
- Identify and eliminate gaps in coverage for both the uninsured and underinsured.
- Find ways to make the health care system more efficient and available.
- Build a comprehensive system that balances the competing interests – private sector, state and federal government.

Statewide Health Care System Task Force - 2003 Members

House of Representatives
Jim Carruthers - Co-chair
Amanda Aguirre
Deb Gullett
Ted Carpenter

Senate
Linda Binder - Co-chair
Dr. Robert Cannell
Carolyn Allen
Dean Martin

Public
Dr. George Burdick - Health Care Provider
Terry Cooper - Consumer Advocacy Group
Kirk Adams - Business Community
Nancy Koff - University of Arizona Health Science Center
Sandy Gibson - Health Insurance Plan

Introduction to AHCCCS

Statewide Health Care Task Force

C.J. Hindman, M.D., Acting Director
Arizona Health Care Cost Containment System
July 15, 2003

AHCCCS

Introduction to AHCCCS

Funding

- Federal
- State
- County
- Private
  - ➢Premiums

AHCCCS Administration

- Medical Policy
- Eligibility (Special Populations)
- Contract for Medical and Long Term Care Services
- Monitor Quality of Care and Financial Viability
- Information Services
- Budget and Claims Processing
- Legal

Intergovernmental Relations

Product Lines

- Medical Care
- Long Term Care
- Healthcare Group
- Premium Sharing (ends 9/17/03)

- Health Plans
- Program Contractors for Long Term Care
- State Agencies
  - ➢DHS
    - CRS
    - Behavioral Health
  - ➢ DES
    - Eligibility
- Fee-For-Service (100,000)
  - ➢Native Americans Referred Off Reservation
  - ➢Emergency Services

AHCCCS

What is Medicaid?

- Medicaid was created by Congress in 1965 to provide health care for low income women, children, the elderly and disabled
- Arizona was the last state to join the Medicaid program in 1982
- The Arizona legislature designed an innovative approach to deliver Medicaid services by using a managed care model
- AHCCCS pays the health plans an actuarially determined monthly payment for each enrolled member and the health plans assume the financial risk for the cost of the medical care

AHCCCS

What is Managed Care?

- Private/public partnership with private insurers, county health systems and providers
- AHCCCS does not provide direct health care services. Health plans deliver medical/long term care
- In order to participate and receive federal dollars, the federal government requires that this payment reflect the increasing cost of care
- The capitation payment made to the health plans is based on the age and sex of the enrolled member
- As the Medicaid agency, AHCCCS regulates compliance with contract terms including quality of care and fiscal accountability
- Evaluations sponsored by the federal government have consistently shown that AHCCCS saves money

AHCCCS Health Plan and Program Contractor Coverage by County

Health Plans

APIPA: AZ Physicians IPA

HC AZ: Health Choice AZ

MCHP: Maricopa Managed Care

MCP: Mercy Care Plan

NEAZ: Family HP of Northeastern AZ

Pima HP: Pima Health Plan

PHP/CC: Phoenix Health Plan

UFC: University Family Care

CMDP: Comprehensive Medical Dental Program (*Statewide)

Program Contractors (PC)

ES: EverCare Select

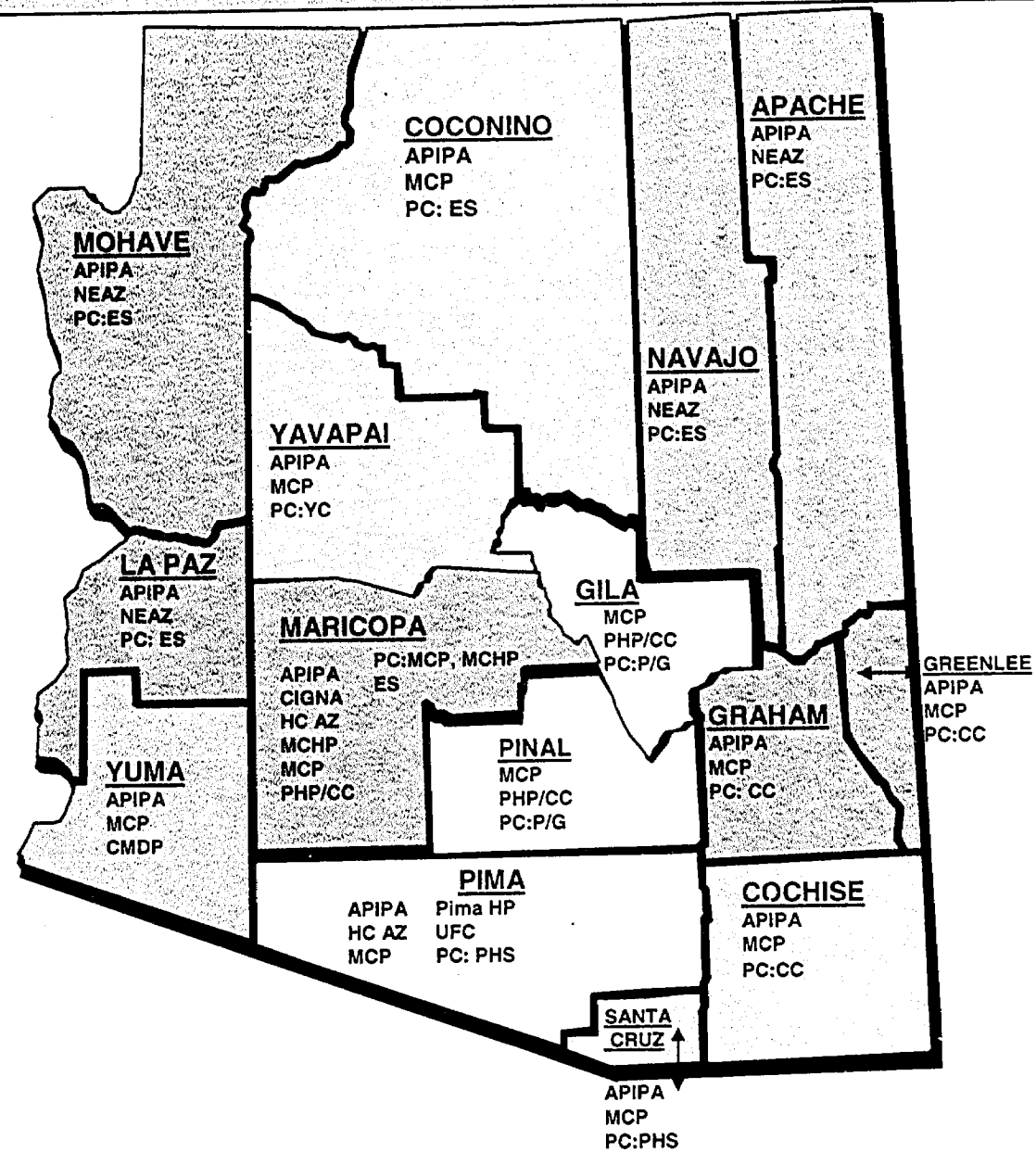
CC: Cochise County

PHS: Pima Health Systems

P/G: Pinal/Gila

YC: Yavapai County

DDD: Division of Developmental Disabilities (*Statewide)



HP and PC Coverage by County 10/1/03
Enrollment by County 7/1/03

AHCCCS

Health Plans

APIPA: AZ Physicians IPA

HC: Health Choice

MCHP: Maricopa Managed Care

MCP: Mercy Care Plan

Pima HP: Pima Health Plan

CC: Community Connection

Care 1st

PHP: Phoenix Health Plan

CMDP: Comprehensive Medical Dental Program (*Statewide)

Program Contractors (PC)

ES: EverCare Select

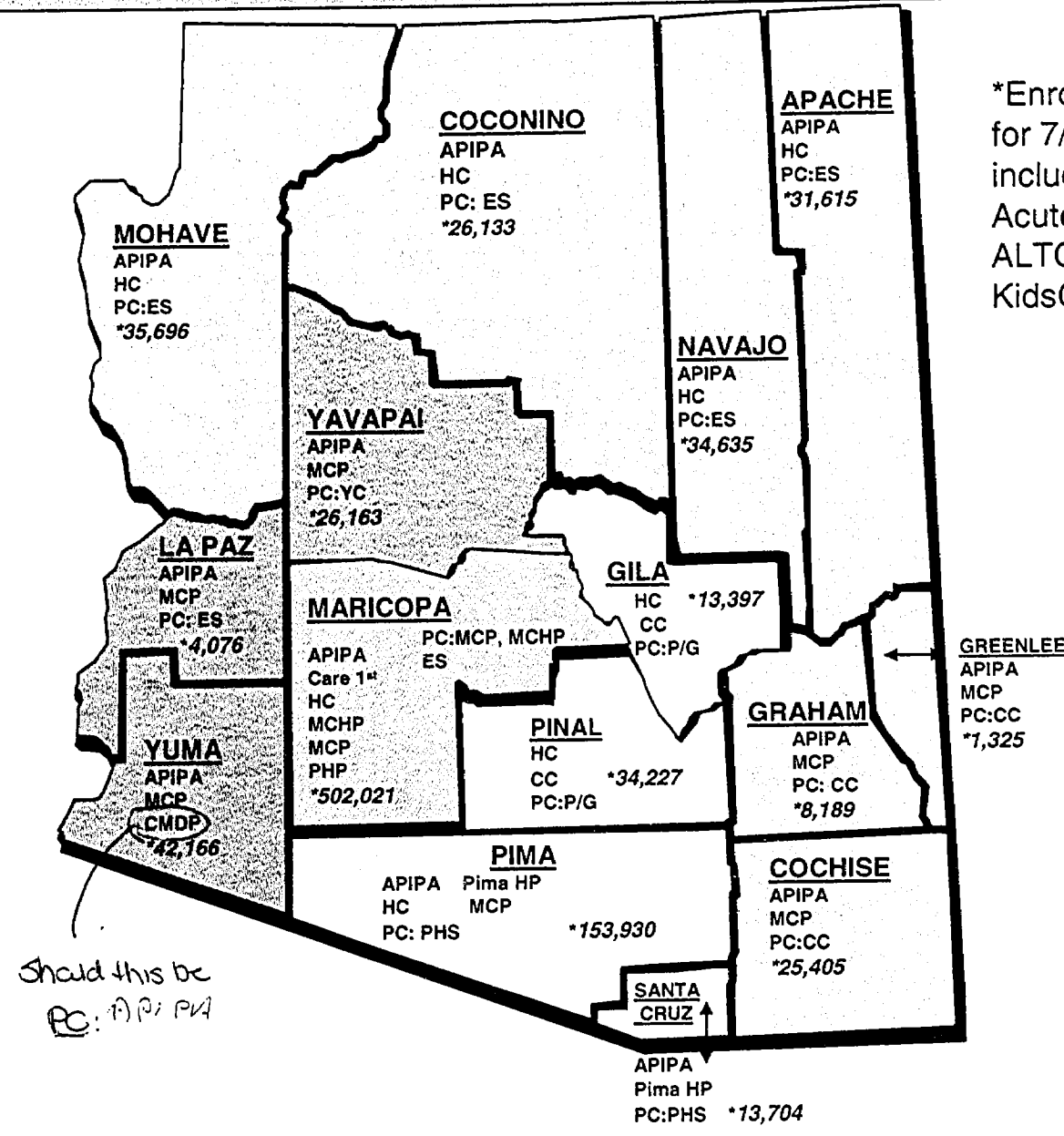
CC: Cochise County

PHS: Pima Health Systems

P/G: Pinal/Gila

YC: Yavapai County

DDD: Division of Developmental Disabilities (*Statewide)



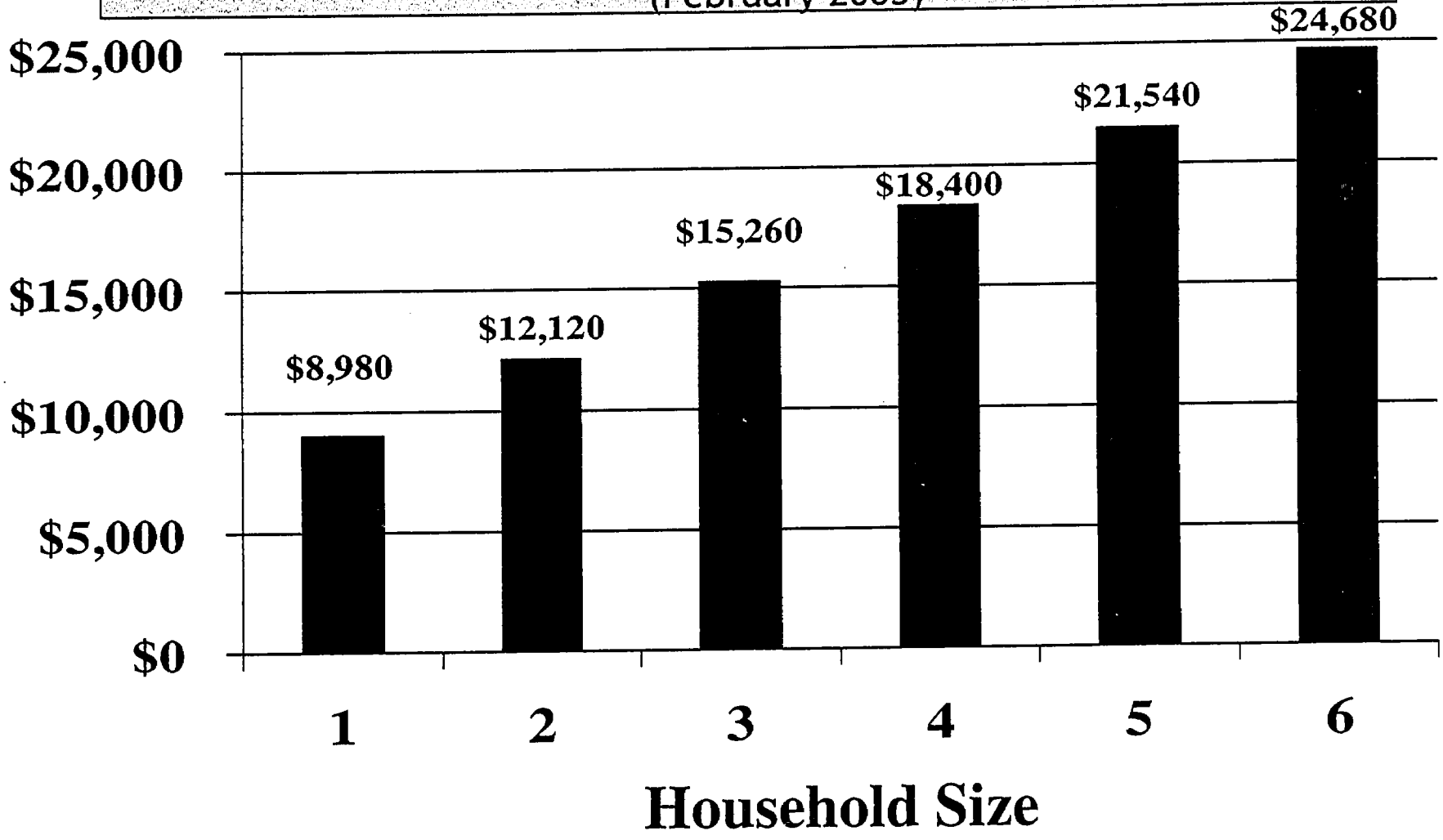
Should this be PC: APi PVI

*Enrollment for 7/1/03 includes Acute, ALTCS and KidsCare

AHCCCS

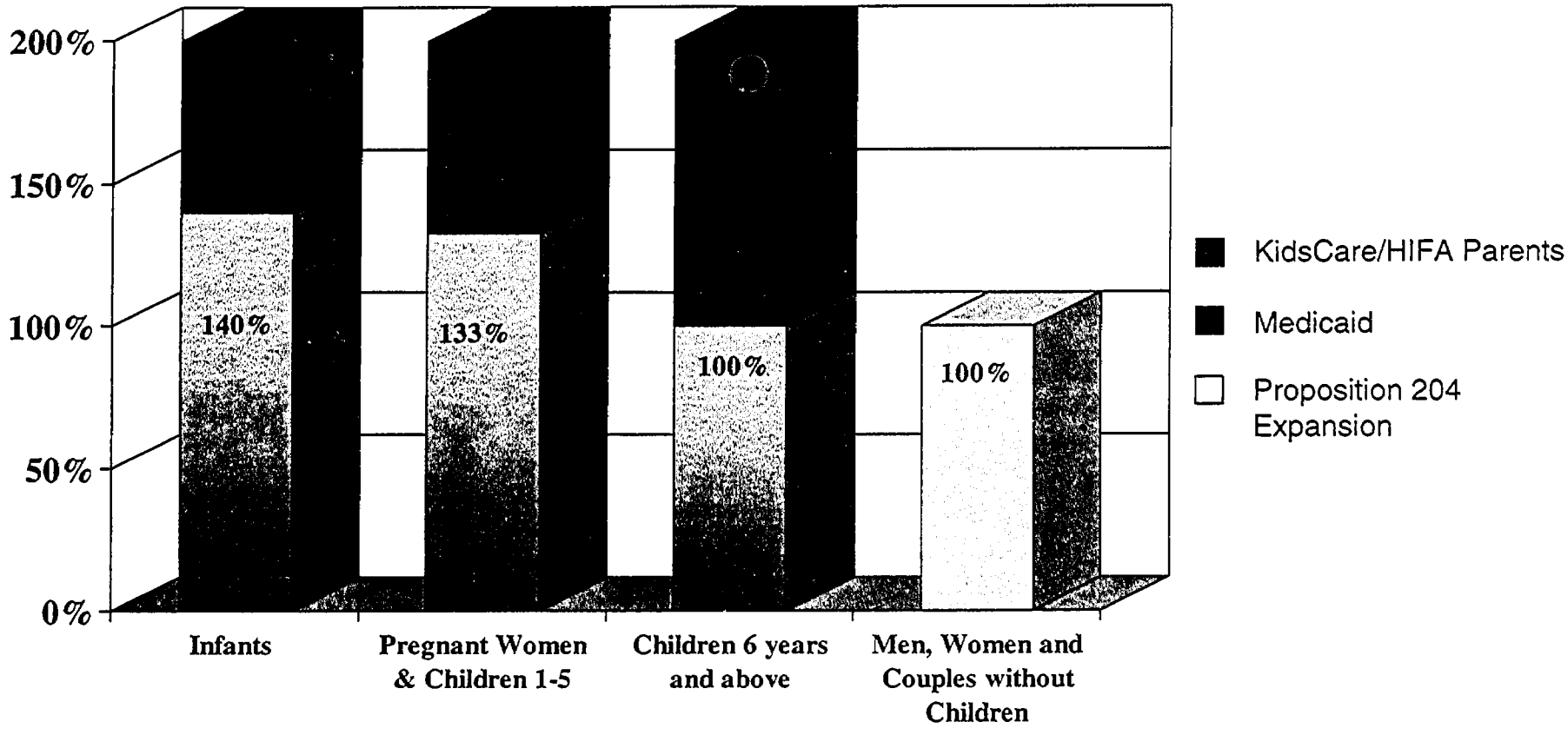
100% Federal Poverty Limit

(February 2003)



AHCCCS

Eligibility Levels

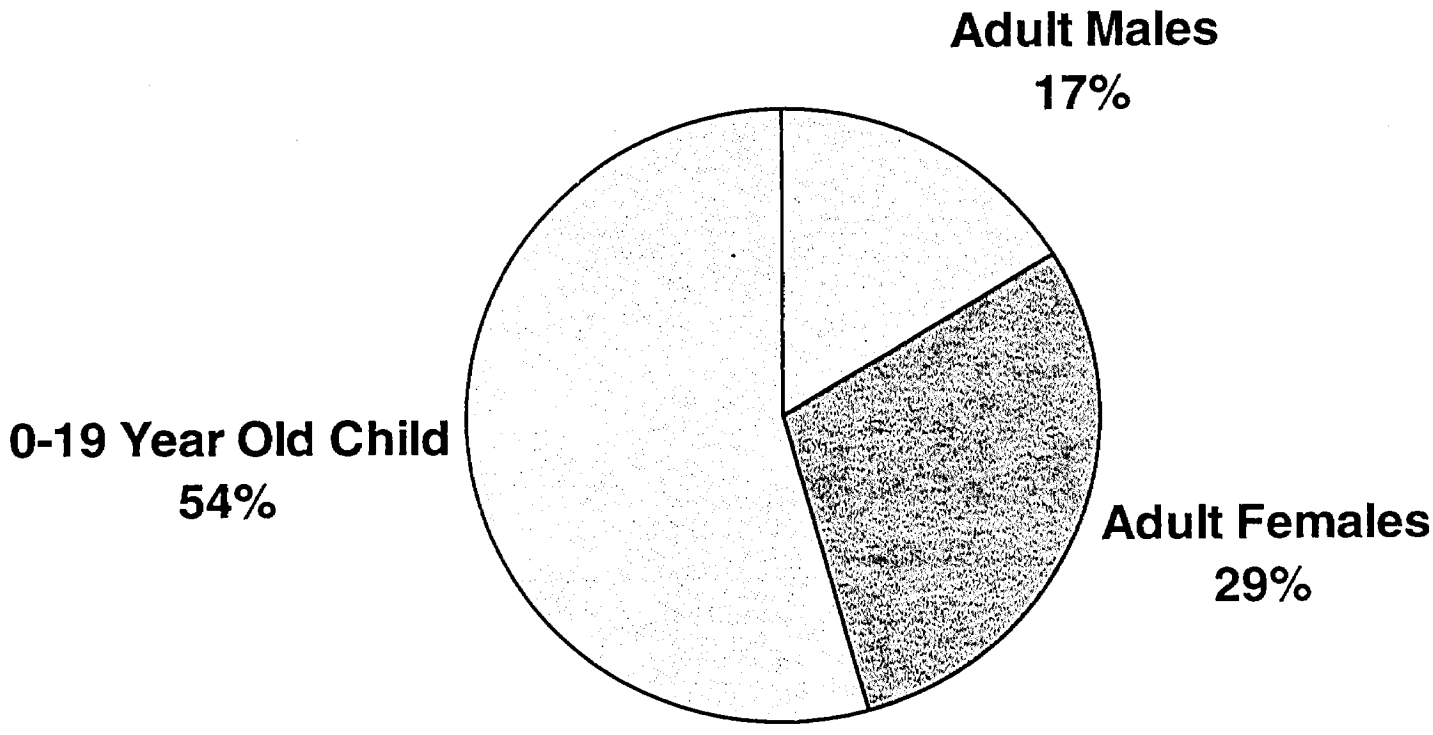


When the HIFA parent program ends on 6/30/04, adults with income above Medicaid eligibility levels are not eligible for any other AHCCCS program.

Note – This chart does not include income levels for optional programs like Ticket to Work and Breast and Cervical Cancer.

AHCCCS

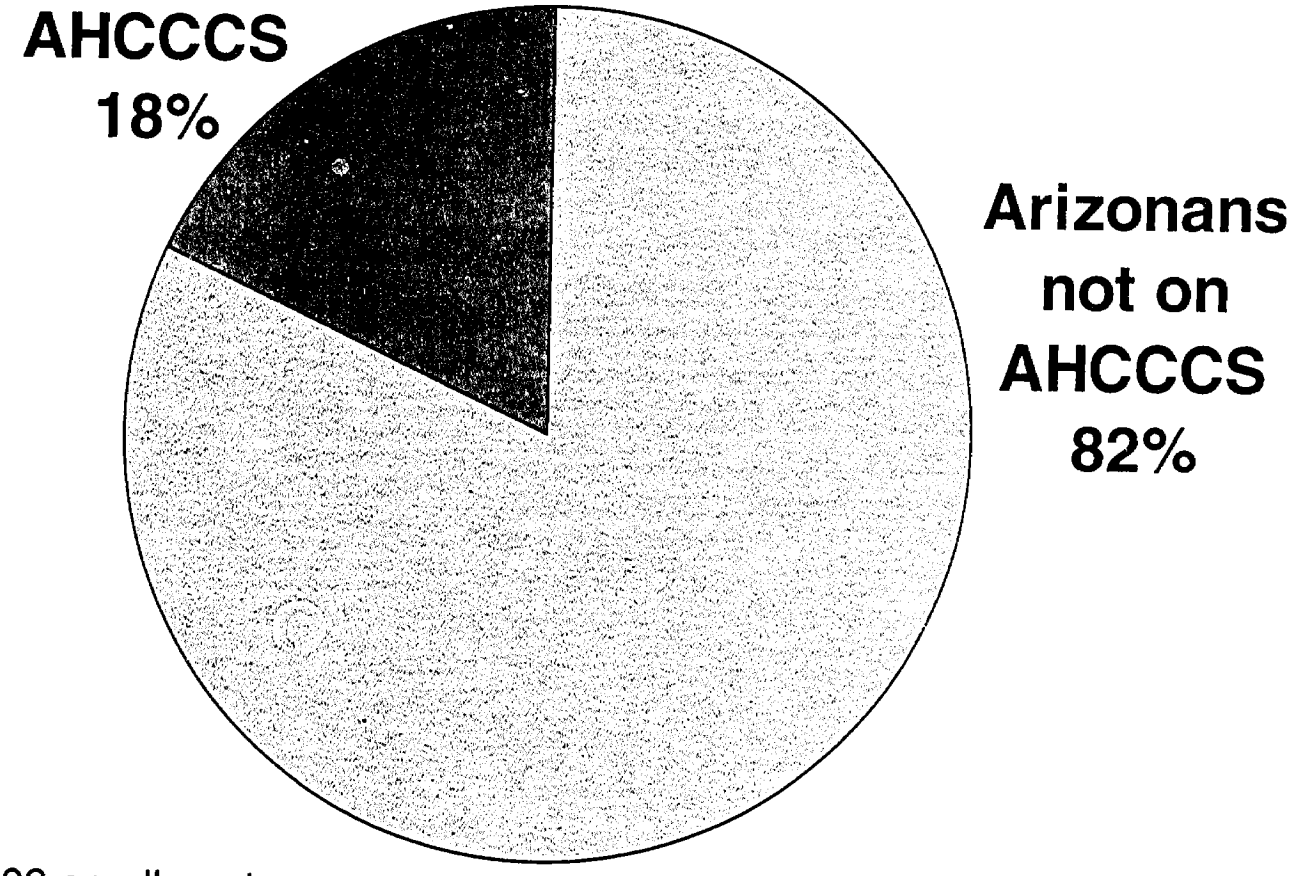
AHCCCS Members



Based on July 2003 enrollment

AHCCCS

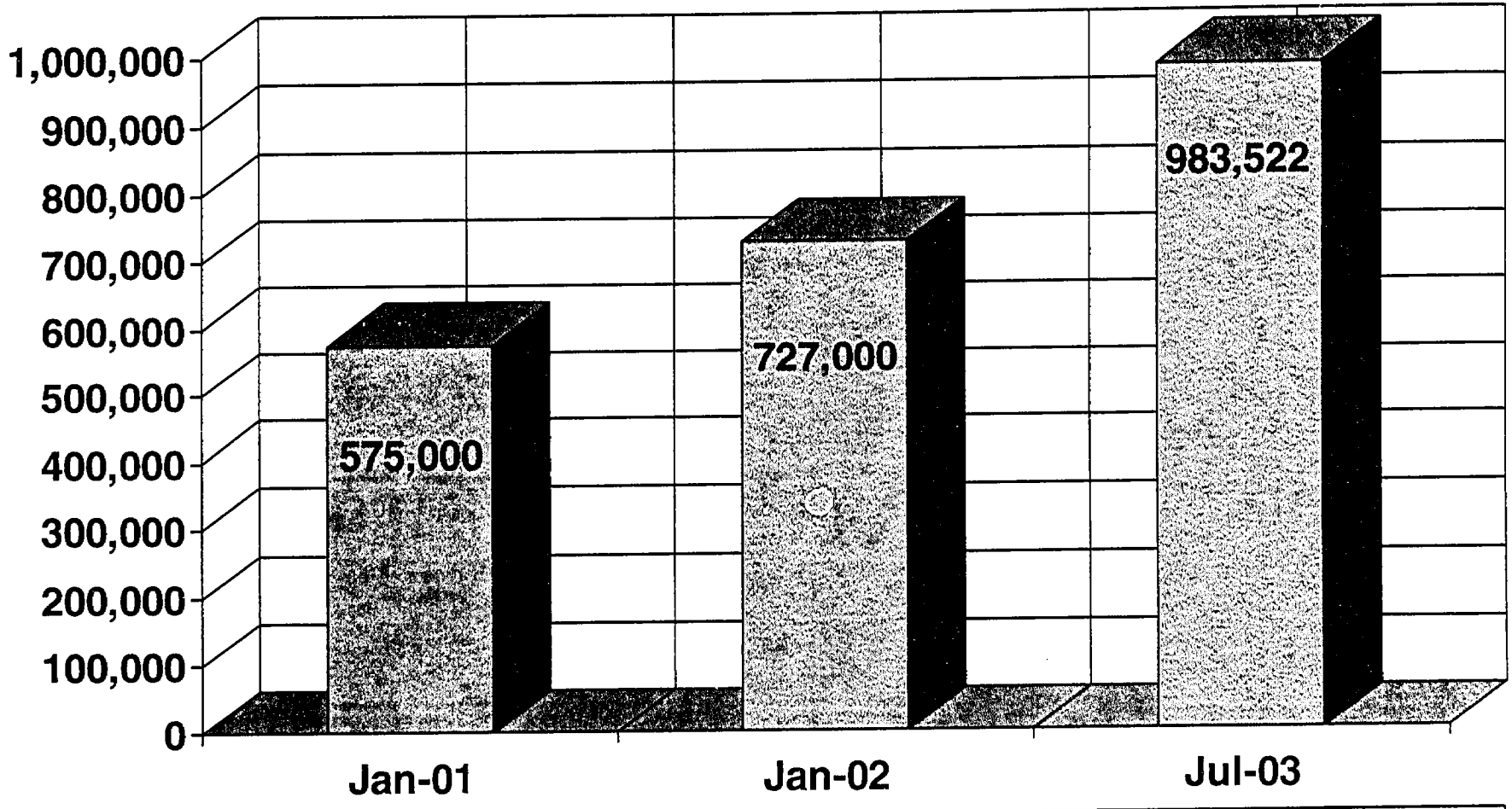
% of Arizonans on AHCCCS



Based on July 2003 enrollment

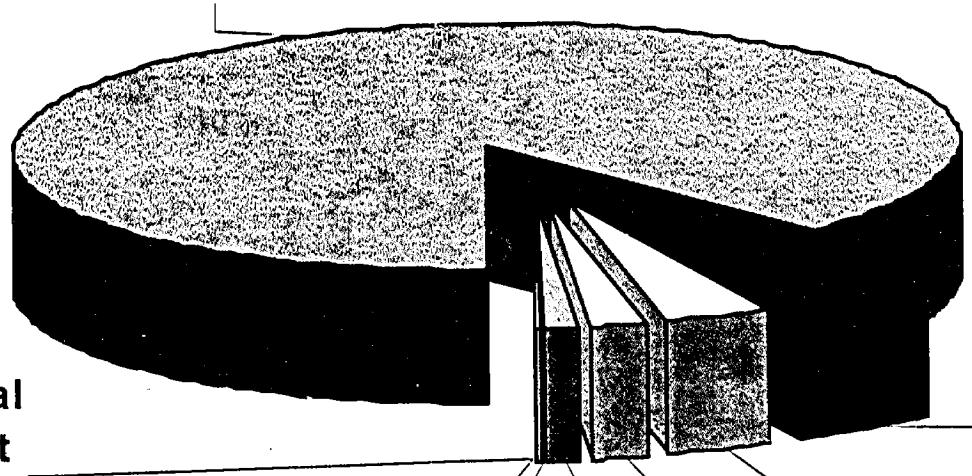
AHCCCS

AHCCCS Growth



*Includes Premium Sharing, Healthcare Group and Medicare Cost Sharing

Percentage of AHCCCS Enrollment by Program



Acute Care
88%

KidsCare
5%

ALTCS
4%

Medicare Cost Sharing
2%

Health Care Group
1%

Premium Sharing Program
Less than 1%

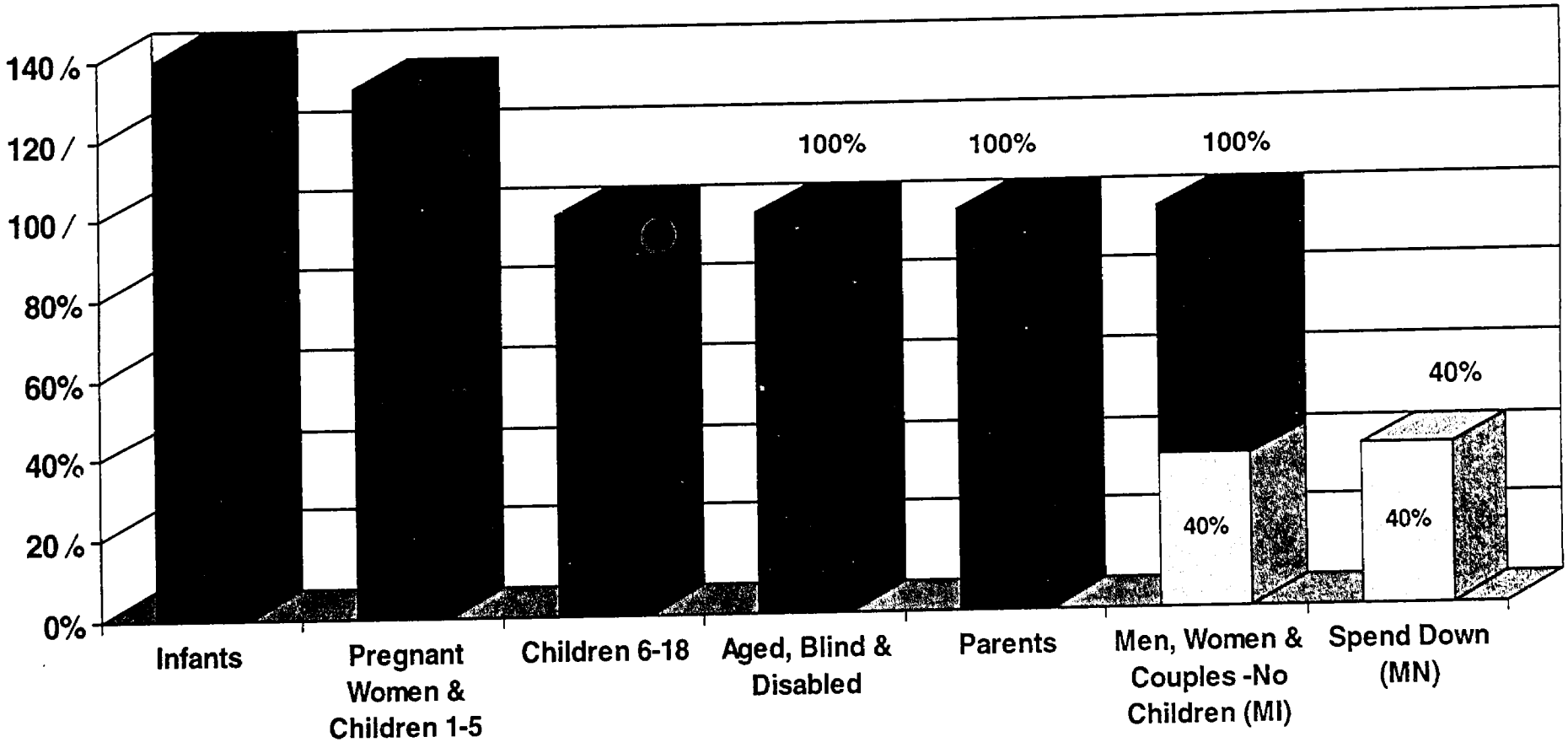
Ticket to Work
Less than 1%

Breast and Cervical Cancer Treatment Program
Less than 1%

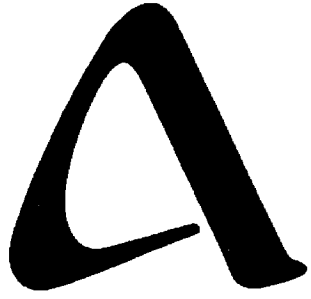
Based on July 2003 enrollment

AHCCCS

Proposition 204 Expansion



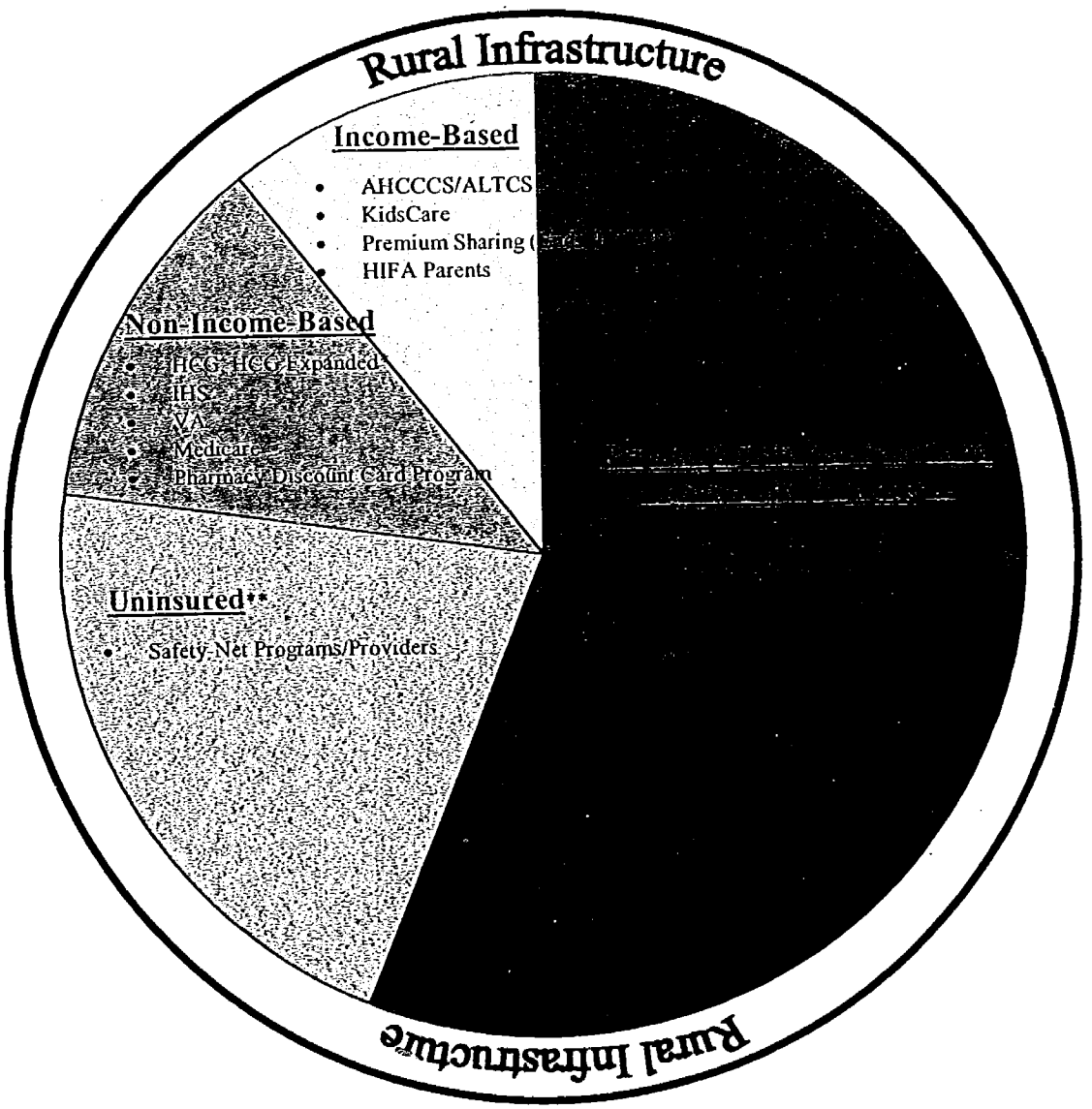
Questions and Discussion



AHCCCS

www.ahcccs.state.az.us

Health Coverage in Arizona



* = Proposed Programs that were being considered by the Task Force

** = Uninsured Characteristics:

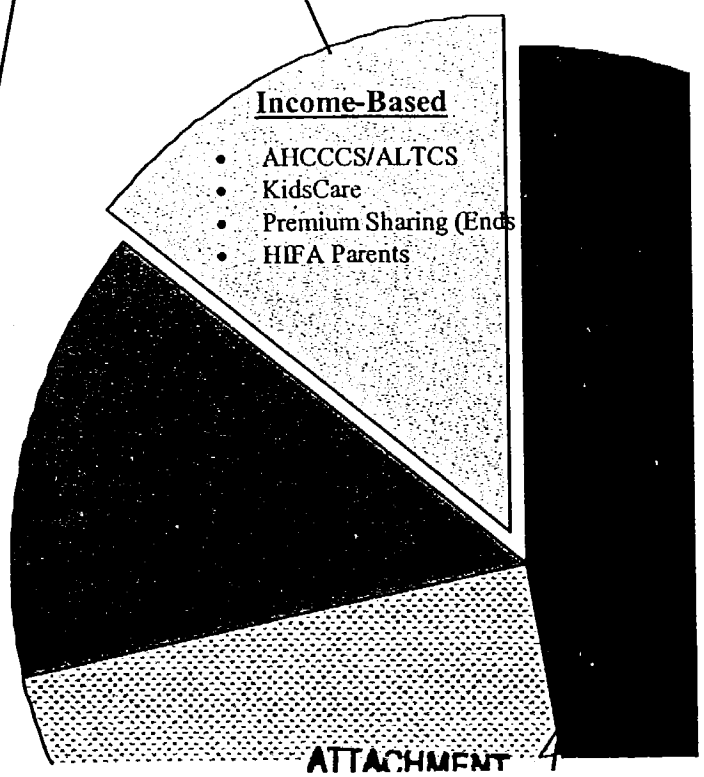
- Rural Areas
- Small & Medium Employers
- Low-Income (not poor)
- Early Retirees
- Elligible, but not enrolled

07/14/03

ATTACHMENT 3

H alth Coverag
in Arizona (Income Based)

Premium Sharing – Chronically Ill Only (limited to certain illnesses and maximum number of participants active at one time) – subsidized coverage *(Ends 9/17/03)*				400% FPL
Ticket to Work (limited to disabled returning to work – allows them to retain Medicaid benefits)	Breast and Cervical Program (under 65 and ineligible for other forms of Medicaid)			250% FPL
ALTCS – 300% SSI or 223% FPL				223% FPL
KidsCare (limited to children under 19)	HIFA Parents	Premium Sharing (requires premium up to 4% of gross income) – subsidized coverage *(Ends 9/17/03)*		200% FPL
Transitional Medical Assistance (TMA)				185% FPL
Medicare – Cost Sharing Programs (up to 175%)				175% FPL
AHCCCS Medicaid – Children Age 1 & Under (SOBRA)				140% FPL
AHCCCS Medicaid- Pregnant Women	AHCCCS Medicaid - Children Ages 1-5 (SOBRA)			133% FPL
AHCCCS Medicaid – Various Programs Based on Income – Prop 204/Title XIX Waiver	Families and Children 1931	AHCCCS Medicaid – Children Ages 6-18	SSI Limited	100% FPL
AHCCCS Medicaid – Spend-down Group (medical expenses reduce gross income to 40% FPL)				40% FPL



Note: New cost sharing measures will be implemented with some programs starting 10/01/03.

Example 1: A family of 4 at 100% of FPL earns $18,400 annually

Example 2: A single individual at 100% of FPL earns $8,980 annually

07/14/03

ATTACHMENT 4

Linda Taylor

From: Tim Sweeney
Sent: Thursday, July 24, 2003 3:21 PM
To: Linda Taylor
Subject: RE: Presentation to the Statewide Health Care Task Force Committee on 7/15/03

As you requested, here is a brief summary of the figures I presented at the Task Force meeting...

As I explained at the meeting, these numbers are rough estimates, and are/were correct to the best of my knowledge (I am not the DES or the DHS analyst here, so I wanted to make the members aware that, as I understood everything, these were the right numbers)

I hope this is what you were looking for.

Tim

DHS (approximate amounts in millions)	FY 03	FY 04
General Fund	302	317
Tobacco Settlement	47	47
Tobacco Tax	13	29
Federal	330	430

included is approximately 18 M in additional Fed aid.

AHCCCS	FY 03	FY 04
General Fund	611	679
Tobacco Tax	134	161
Tobacco Settlement	65	45
County Funds	263	260
Federal	2,400	2,800
CHIP	95	113

included is approximately 97 M in additional Fed aid (including some for counties)

DES	FY 03	FY 04
General Fund	186	201
Other Funds	18	21
Federal	293	334

included is approximately 97 M in additional Fed aid (including some for counties)

----Original Message----
From: Linda Taylor
Sent: Thursday, July 17, 2003 2:01 PM
To: Tim Sweeney
Subject: Presentation to the Statewide Health Care Task Force Committee on 7/15/03

Could you e-mail or send over (House - Room 125) a copy of the figures you presented to the Committee - for the minutes? I would really appreciate it.

ATTACHMENT 5

University of Maryland Center on Aging

Partnership for Long-Term Care

UMCA

Approximately 40 percent of the 65-and-over population will eventually need long-term care, with an average stay of 2.5 years at a cost ranging from $30,000-$65,000 annually. And although many elderly Americans still believe that their long-term costs will be covered by Medicare, the truth is that only after spending down to impoverishment will they receive public support through Medicaid.

The Partnership for Long-Term Care provides an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long term care insurers. Participating states work with insurers to create insurance policies that are more affordable and provide better protection against impoverishment than those commonly offered. Once private insurance benefits are exhausted, special Medicaid eligibility rules are applied if additional coverage is necessary.

The authority for instituting the Partnership for Long Term Care (PLTC) program resides in state plan amendments rather than Centers for Medicare and Medicaid Services (CMS) waivers. There is a provision in Medicaid law that allows a state to alter the asset eligibility criteria dependent on a state specified requirement. In this case, it is the purchase of a state certified long term care insurance policy.

The Partnership is sponsored by The Robert Wood Johnson Foundation.

Partnership Update

- Overview
- Fact Sheet
- OBRA 1993
- Replication Activity
- Publications
- Participating Insurers
- Contacts

Partnership Presentation

- Partners In Social Marketing

Related Links

- California
- Connecticut
- Indiana
- New York

Questions and comments regarding the Center on Aging can be directed by E-mail to speters@wam.umd.edu

UMCA Homepage

Last Updated 10/24/02

ATTACHMENT 6

ARIZONA STATE LEGISLATURE

Interim Meeting Notice

Open to the Public

Statewide Health Care System Task Force

DATE: **Wednesday, October 15, 2003**

TIME: **1:00 PM**

PLACE: **Senate Appropriations Room 109**

A G E N D A

1. Opening Remarks
2. Update on Working Group Activities
   - High Risk Pool
   - State Employee Self-Insurance
3. Department of Insurance
   - Overview of Health Insurance Market
   - Arizona Regulatory Policies
4. Committee Discussion
5. Public Testimony
6. Adjourn

MEMBERS:

Senator Binder - Cochair
Senator Allen
Senator Cannell
Senator Martin

Representative Carruthers - Cochair
Representative Aguirre
Representative Carpenter
Representative Gullett

Kirk D. Adams
Dr. George Burdick
Terry Cooper
Sandy Gibson
Nancy Koff

tm
11/26/2003

People with disabilities may request reasonable accommodations such as interpreters, alternative formats, or assistance with physical accessibility. If you require accommodations, please contact the Chief Clerk's Office at (602) 542-3032, (TDD) 542-6241.

ARIZONA STATE LEGISLATURE

STATEWIDE HEALTH CARE SYSTEM TASK FORCE

Minutes of the Meeting
Wednesday, October 15, 2003
1 p.m., Senate Appropriations Room 109

Members Present:
Senator Linda Binder, Cochair
Senator Dean Martin
Mr. Kirk D. Adams
Dr. George Burdick
Mr. Terry Cooper
Representative James Carruthers, Cochair
Representative Amanda Aguirre
Representative Ted Carpenter
Representative Deb Gullett
Ms. Sandy Gibson

Members Absent:
Senator Carolyn Allen
Senator Robert Cannell
Ms. Nancy Koff

Staff:
Julie Keane, Senate Health Committee Analyst

Senator Binder called the meeting to order at 1:12 p.m., attendance was noted, and each member of the Committee introduced themselves.

Representative Gullett presented an update on self-insurance, providing a handout (Attachment 1) compiled by the Arizona Department of Administration (ADOA). She explained that ADOA recently requested bids and received a number of excellent proposals from insurance carriers that also included coverage for rural areas. Based on these proposals, it appears that a self-insurance health plan could be cost effective and provide improved medical coverage in all areas of the State. She pointed out that 36 states are self-insured, as well as many large corporations.

Representative Gullett noted that this year, CIGNA increased their premiums by 23%, although they suggested a 49% premium increase for the Preferred Provider Organization (PPO) plan. It is projected that next year, the average premium increase for private insurance companies will be 19%.

Ms. Gibson provided an update on high-risk pools, explaining that her work group discussed the concept and purpose of a high-risk pool, which is to provide a safety net to give coverage to people who are uninsurable because of medical conditions. She indicated that some research has already occurred, specifically by Senator Leff. The work group discovered that there is help available for states through the Federal Trade Assistance Act; however, there are many requirements attached so they decided to abandon the idea.

Ms. Gibson pointed out that when establishing a high-risk pool, one of the biggest decisions is to determine whether the Health Insurance Portability and Accountability Act (HIPAA) group would

be included. Most high-risk pools do include the HIPAA individuals; therefore, the work group is considering doing so.

In response to Senator Binder, Ms. Gibson replied that Senator Leff did pass legislation in the past couple of years that included high-risk pools; however, it was not funded. She stressed that the challenge is how to fund this type of legislation.

Representative Carruthers expressed his concern that he would not want the self-insurance plan to be only a high-risk pool. Ms. Gibson agreed that the dilemma is how to keep the high-risk pool for the purpose it is intended, which is a safety net for a relatively small population. She suggested that the key to success is to establish excellent criteria for those who would qualify for the high-risk pool.

Representative Aguirre noted that the size of the high-risk pool might be determined by the number of retirees 65 years of age and older who do not have a supplement to Medicare.

Vista Brown, Legislative Liaison, Department of Insurance (DOI), distributed a packet of information including a document entitled Arizona's Health Insurance Market (Attachment 2) which covers: 1) health care financing; 2) private commercial health insurance marketplace; 3) top 10 accident and health insurers in Arizona; 4) insurers authorized to write health insurance in Arizona; 5) HIPAA; 6) rate regulation; and 7) trends. She emphasized that DOI does not regulate the entire insurance marketplace, noting a concern that when laws are passed, there are a number of areas that are not impacted.

Ms. Brown also pointed out that in the handout there are additional documents showing the 2002 ranking of the top 25 insurers by premiums written for accident and health policies (Attachment 3), as well as for all other health care plans (Attachment 4). She clarified that "accident and health" is a broad term that covers several different types of insurance such as major medical, income disability, limited benefits, and various others. There are 464 insurance companies reporting some volume of business writing health insurance policies in Arizona, with only 40 companies reporting 500 or more policyholders as identified in the 2002 Market Analysis Survey (Attachment 5). There are 46 accountable health plans in Arizona (Attachment 6) that include Health Maintenance Organization (HMOs) and indemnity insurers writing small and large group policies.

Ms. Brown next discussed HIPAA, noting the small group premium and tax exempt data (Attachment 7). She also talked about the rating band law, explaining that DOI can disapprove a policy form if benefits are unreasonable in relation to the premium charged. She mentioned that the industry trends include: 1) higher premiums; 2) reduction in benefits; 3) insured paying greater share of premium; 4) Medical Savings Accounts (MSAs) and discount plans; and 5) blending of products.

In response to Representative Carruthers, Ms. Brown replied that according to the Center for Studying Health System Change, there does not appear to be any relief in premium increases anytime soon. Senator Binder requested that a copy of the report be distributed to Committee members to review. Ms. Gibson added that she has heard that the acceleration of the increases in the future will not be as steep as they were last year.

Representative Aguirre wondered if there is a study showing how many small business employees have lost benefits because of the increased rates, as well as those employees who have had to incur a larger portion of the premium.

Representative Gullett pointed out that there are 900,000 Arizonans on the Arizona Health Care Cost Containment System (AHCCCS). She inquired as to whether more people have moved to the AHCCCS roles who used to be insured by a private insurance company; thus increasing the cost to the State. Ms. Gibson replied that the overall small group insurance market has been relatively flat.

Dr. Burdick suggested that the trend where individuals move from private commercial insurance to self-insurance can be a good thing. The problem is lack of tax incentives for private individuals.

Mr. Adams asked for clarification regarding the discrepancies of market share for United Healthcare between the two reports (Attachment 3 and 4). Ms. Brown replied that one report represents United Healthcare's HMO market share and the other report represents their indemnity group.

Mr. Adams wondered why Blue Cross/Blue Shield's (BC/BS) loss ratio was not listed on Attachment 3, since they are the largest provider in the State. Ms. Brown explained that BC/BS is listed on Attachment 4 because of the nature of their license.

Mr. Adams stated that as he reviews the loss ratios, the top ten insurers have extremely high loss ratios, which does not include their expense ratios. It appears that the companies that are insuring the highest number of Arizonans are not doing very well, which may account for the rate increases. He inquired about the long-term solvency of the companies. Ms. Brown noted that all of the insurers are subject to risk-based capital requirements, which includes minimum provisions, as well as a complicated analysis requirement. All insurers on the report are in compliance with these requirements. She suggested that is one of the reasons for the premium increases, because the insurers have not been profitable and are seeking to return to profitability.

Mr. Adams questioned if DOI has information on the combined ratios for each of the companies. Ms. Brown replied that the data is available. Mr. Adams added that he feels that information would be helpful to the Committee, because it would provide a more accurate picture of how much money a company is making or losing. Ms. Gibson mentioned that accident and health carriers tend to be the smaller companies; the larger companies typically do not have an accident and health license. She explained that Arizona is perceived as a fairly robust competitive viable market, noting that all of the major national carriers operate in Arizona. She added that carriers lost money in the mid-1990s and now most of them are on the upswing, with all carriers having adequate surplus. She said that she feels that all companies are solvent.

In response to Mr. Adams question, Ms. Gibson noted that most health insurance carriers have made a profit in Arizona in the past two years. Mr. Adams suggested that the trend is to increase costs each year. The average rate increase has been recorded as 19%, which is important to stress that is an average number. Many small businesses are experiencing rate increases much larger than 19%. He explained that his company renewal rate was 36% on top of the 25%

increase the previous year. As a result, the company had to reduce benefits and ask employees to contribute more. There is a trend among providers for age banding on group policies, when traditionally each employee paid the same rate regardless of age. Ms. Brown indicated that she is not aware of that because DOI does not receive rate filings. Ms. Gibson noted that to develop premium rates for groups, most carriers look at the age of the individuals.

Mr. Adams commented that insurance companies are obligated to operate to provide stockholders with a return on their investment. He suggested that the activities of the Committee are timely, because he feels that the small business owners are headed for a crisis. He emphasized that when businesses employing less than 100 people are unable to offer health insurance coverage, someone will look at serious reforms in the healthcare system. He indicated that anything this Committee can do to encourage more competition in the insurance industry would go a long way in preserving the insurance offered to employees of small businesses. He stressed that he feels the political community has not had the will to do what needs to be done to reform, not just the delivery of the healthcare services, but also the factors that are driving costs up.

Dr. Burdick stated that the loss ratios on the report only reflect Arizona and suggested that it would be helpful to review the national medical loss ratios. Ms. Gibson noted that medical loss ratios are difficult to compare without taking into account other factors, such as mix of business. She explained that the pure overhead ratios tend to range between 10% to 13% of premium.

In response to Senator Binder, Ms. Brown replied that the trend is to not regulate rates. It is presumed that a competitive market will regulate the rates.

In response to Representative Carpenter, Ms. Brown explained that the long-term driver of cost is new technology and procedures. Short-term drivers of cost include hospital consolidation, labor shortages, new drugs, and advertising.

Senator Martin stressed that the more rates are regulated, costs will increase. Mr. Adams added that one of the most striking things in the DOI presentation is the low number of insurers that are actively marketing individual health insurance. If the rate regulation was increased for the insurance companies, he said that the number of insurers willing to participate would be reduced. He submitted that the health insurance market in Arizona would be better with more insurers actively scrambling for market share, thus doing their best to keep costs down.

Representative Carpenter suggested that if it is determined that Arizona should become self-insured, it is important to ensure the program is not raided when times are tough. Also, it would be necessary to ensure the premiums are adequate to keep the program operating.

Representative Carruthers stated that the Committee needs to have some recommendations put together by December for all members to review. He reminded the members that whatever they decide on, they will need to sell it to the remaining legislators.

Senator Martin brought up the fact that the State used to have a plan with six or seven options. Self-insurance is not the only way to get more options; that decision is made when drafting the Request for Proposal (RFP).

Representative Gullett pointed out that Ms. Bayless is most interested in the cost-cutting options that may be available in the self-insurance program.

Marie Elizabeth Wells, Representative, Silver Haired Legislature, distributed a booklet (Attachment 8) regarding mandatory health insurance. She explained that in Arizona, there are one million people uninsured, one million on AHCCCS, one million on Medicare, and three million insured. She pointed out that just because a person is employed does not mean they are covered by insurance, since there is no mandate that businesses offer insurance to their employees. Of the one million uninsured in Arizona, a large portion have sought to purchase individual policies and are denied coverage based on various health conditions such as high blood pressure or job descriptions such as part-time status. She stressed that these citizens are responsible and employed; however, they are not offered the opportunity to purchase group health insurance. A group policy that allows minimal catastrophic coverage reduces the emotional strain of an unexpected serious illness that could devastate a person's assets and potentially lead to bankruptcy.

Ms. Wells referred to the booklet, noting that it provides facts and figures on the uninsured and how they are less likely to get well from serious illness. The booklet also has a review of a recent bill signed in California that designates companies with over 50 employees to offer health insurance.

There being no further business, the meeting was adjourned at 2:35 p.m.

Respectfully submitted,

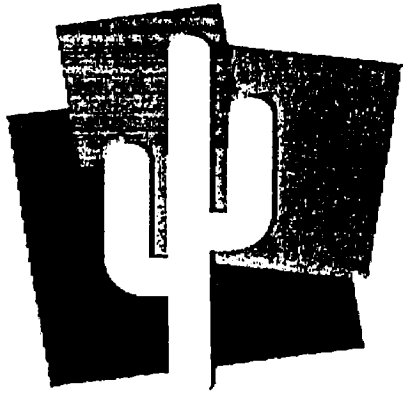
Carol Dager

Carol Dager
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

ADOA
Arizona Department of Administration

THE SAGUARO PROGRAM



FOR YOUR BENEFIT

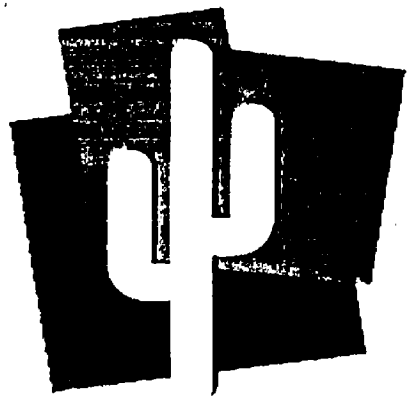
Educational Briefing on Self-Insuring of Health Benefits

Attachment 1

5/15/03

ADOA
Arizona Department of Administration

THE SAGUARO PROGRAM



FOR YOUR BENEFIT

Educational Briefing on Self-Insuring of Health Benefits

Attachment 1

10/15/03

Saguaro Program Facts

- The Saguaro Program covers approximately 52,000 State employees and 8,200 retirees. This equates to approximately 120,000 total covered lives.
- For the plan year beginning 10/1/03, the State implemented a 13% overall increase for health insurance. ADOA will pay approximately $400 million to CIGNA for the 10/1/03-09/30/04 plan year. It is anticipated the State will continue to incur double-digit increases for the next 5 years due to rising healthcare costs.
- According to a recent article in the Arizona Republic, healthcare premiums are expected to rise 12.6% in Phoenix and nationally in 2004.
- A recent Kaiser Family Institute study indicates for the past five (5) years, fully insured programs have experienced a 61% increase in health insurance premiums, while self-insured program have only risen 42%. Self-insured programs are better able to control and mitigate rising healthcare costs.

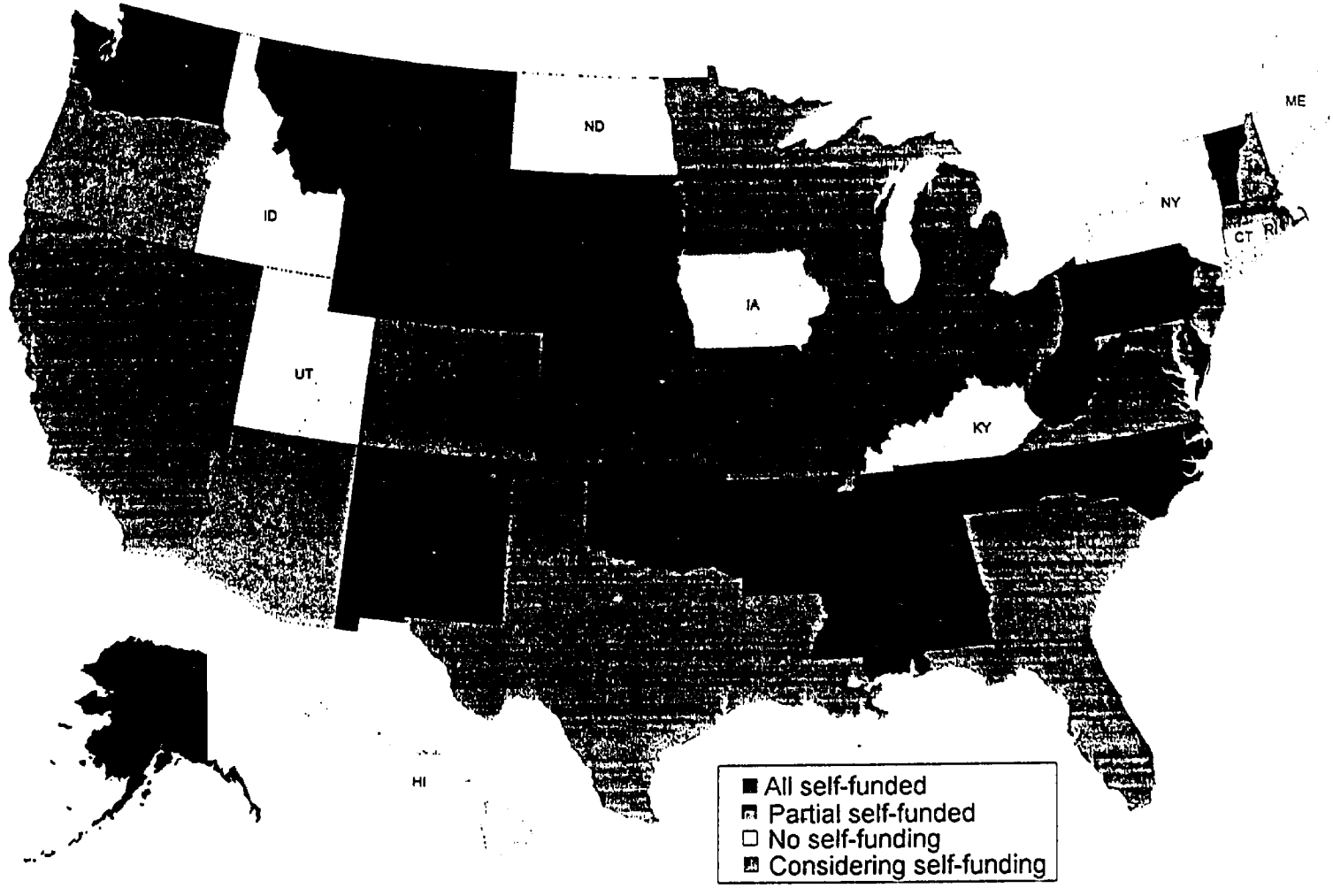
Goals of Self-Insuring

Maximize value of health benefits to State employees through improved choice and program design

- Employees: *Improved CHOICE*
  - Increased Choice in Providers
  - Improved Choice in Plan Design
- State: *Improved PROGRAM DESIGN*
  - Better understanding of treatment patterns to develop customized program
  - Increased flexibility over program decisions

Other States That Self-Insure

Self-funding of State Employee Health Plans



Status of Implementation

- Six (6) RFP's were issued for self-insurance:
  - Third Party Administrator
  - Medical Network
  - Pharmacy Benefit Manager
  - Dental Network
  - Utilization Review/Management
  - Stop-Loss Insurance
- Based on the proposals received, ADOA believes employees/retirees will receive improved network and physician choice throughout the State.
- A communications strategy is being developed. Statewide focus groups of employees and retirees have been surveyed on self-insurance. A dedicated website, direct mail communications, and informational meetings will be initiated based on the focus group comments and questions.

Arizona's Health Insurance Market

Presentation to the Statewide Health Care Task Force
Vista Thompson Brown
Arizona Department of Insurance
October 15, 2003

Health Care Financing

- Private commercial health insurance
  (Group and individual)
- Employer sponsored benefit plans
  (ERISA plans: self-funded & insured)
- Healthcare Group
  (Small group coverage; includes "groups of 1")
- Medicaid (AHCCCS)
- Medicare & Medicare+Choice
  (Medicare Supplement)
- Miscellaneous: CHAMPUS, VA, Indian Health

Private Commercial Health Insurance Marketplace

- Large group
- Small group (2-50)
- Individual

Attachment 2
10/15/03

Health Care Services Organizations

Cigna HealthCare of Arizona	267,840 AZ members**
Pacificare of Arizona	229,721
Aetna Health Inc.	205,114
United Healthcare of Arizona	138,097
Health Net of Arizona	116,859
Humana Health Plan, Inc.	51,962
Sun Health Medisun, Inc.*	16,393
One Health Plan of Arizona	7,119

*Predominantly Medicare+Choice ** Source: 2002 Annual Statements

Hospital, Medical, Dental, Optometric Service Corporations ("HMDOs")

Blue Cross Blue Shield of Arizona, Inc.	770,142* Arizona subscribers * Includes those eligible for services under self-insured and network rental programs administered by BCBS.
Mayo Health Plan of Arizona (in run-off; plans to surrender license effective 1/1/04)	30,200 Arizona members

Top 10 Accident and Health Insurers

Insurer	Major Medical AZ policies (02)*
United Healthcare IC	57,013
Connecticut General Life IC	43,939
Humana Insurance Company	26,535
Corporate Health IC	24,082
Health Net Life IC	23,504
Mega Life And Health IC	12,238
United Wisconsin Life IC	11,875
Fortis Insurance Company	10,626
Aetna Life Insurance Company	8,458
Golden Rule Insurance Company	7,244

*Source 2002 Market Analysis Survey

Insurers Authorized to Write Health Insurance

- 464 Licensed disability insurers ("indemnity")*
  Only 40 insurers reporting at least 500+ major medical policyholders, and only 8 insurers reporting at least 10,000+ major medical policyholders.
- 46 Accountable health plans
  Includes HMOs, HMDOs, and indemnity insurers writing small and large group policies.
- 24 Insurers are "actively marketing" individual health insurance

* Many insurers offer only "limited benefits" products

HIPAA

- Small group market (2-50)
  - Guaranteed issue to all small groups
  - Premium tax exemption (A.R.S. § 20-2304)
  - Must participate if selling to large groups
- Individual market
  - Guaranteed issue to "HIPAA eligibles" without preexisting condition limitations
    - 18 months of creditable coverage, the most recent of which was group coverage
    - No breaks in coverage of longer than 63 days

"Rate Regulation"

- Large group - not subject to regulation
- Small group - have to certify compliance with rate band in A.R.S. § 20-2311
- Service corporations (HMDOs) and disability insurers (as to individual insurance)
  - ADOI can disapprove a policy form if benefits are unreasonable in relation to the premium charged. A.R.S. § § 20-826(L), 20-1342.02.
    - Individual - loss ratios in A.A.C.R20-6-607

Rate Regulation - continued

- HMOs
  - No requirement to file premiums
  - File co-pays as "variables"

Trends

- Higher premiums
- Reduction in benefits
- Insured/employee paying greater share
- Away from private commercial insurance to self-insurance and less-regulated alternatives (MSAs, discount plans)
- "Blending" of products

ACCIDENT AND HEALTH

Includes Accident and Health Insurance business written by Property and Casualty insurers

2002 Ranking of Top Twenty-Five Insurers by Premiums Written

($000 Omitted)

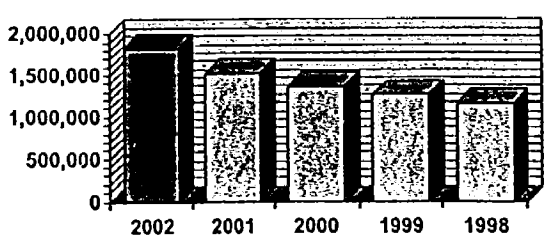
NAIC#	INSURER NAME	Market Share '02	Market Share ('01)	PREMIUMS WRITTEN (1)	PREMIUMS EARNED (2)	LOSSES PAID (3)	LOSSES INCURRED (4)	LOSS RATIO (4)/(2)
1. 79413	UNITED HEALTHCARE INS CO	10.1%	(8.0%)	183,335	181,624	144,211	147,219	81.1%
2. 62308	CONNECTICUT GENERAL LIFE INS CO	8.0%	(1.7%)	146,137	148,510	132,538	137,153	92.4%
3. 73288	HUMANA INS CO	5.8%	(4.9%)	105,167	103,649	80,497	84,851	81.9%
4. 66141	HEALTH NET LIFE INS CO	4.8%	(3.9%)	88,041	85,139	69,127	68,743	80.7%
5. 65978	METROPOLITAN LIFE INS CO	3.5%	(3.9%)	64,390	63,955	55,357	60,795	95.1%
6. 84506	PACIFICARE LIFE ASSURANCE CO	3.1%	(2.6%)	57,297	57,903	34,982	32,825	56.7%
7. 62235	UNUM LIFE INS CO OF AMERICA	2.6%	(3.0%)	47,998	48,186	42,302	58,393	121.2%
8. 97179	UNITED WISCONSIN LIFE INS CO	2.4%	(2.4%)	44,376	44,384	7,603	7,533	17.0%
9. 60305	AMERICAN COMMUNITY MUTUAL INS CO	2.1%	(3.4%)	38,862	38,852	31,968	31,002	79.8%
10. 71412	MUTUAL OF OMAHA INS CO	1.9%	(1.9%)	33,973	33,464	18,892	18,852	56.3%
11. 61271	PRINCIPAL LIFE INS CO	1.8%	(2.2%)	33,473	33,130	26,177	26,454	79.8%
12. 61425	TRUSTMARK INS CO	1.8%	(2.0%)	32,328	32,346	41,574	48,516	150.0%
13. 60054	AETNA LIFE INS CO	1.6%	(1.3%)	29,858	28,631	22,509	23,507	82.1%
14. 69477	FORTIS INS CO	1.6%	(1.3%)	29,339	28,526	13,578	14,483	50.8%
15. 60380	AMERICAN FAMILY LIFE ASSURANCE CO OF COLUMBUS	1.5%	(1.4%)	27,367	28,035	10,398	11,438	40.8%
16. 69019	STANDARD INS CO	1.5%	(1.6%)	27,099	26,712	18,362	20,280	75.9%
17. 65080	JOHN ALDEN LIFE INS CO	1.4%	(1.5%)	24,842	24,336	16,977	18,147	74.6%
18. 70025	GENERAL ELECTRIC CAPITAL ASSURANCE CO	1.3%	(1.3%)	23,830	22,891	6,829	8,223	35.9%
19. 62286	GOLDEN RULE INS CO	1.2%	(0.9%)	21,710	21,443	13,949	14,297	66.7%
20. 97268	PACIFIC LIFE & ANNUITY CO	1.2%	(0.9%)	21,173	21,241	15,459	15,730	74.1%
21. 69868	UNITED OF OMAHA LIFE INS CO	1.1%	(1.7%)	20,506	19,369	16,524	15,030	77.6%
22. 60836	AMERICAN REPUBLIC INS CO	1.1%	(1.4%)	19,750	19,925	12,412	11,447	57.5%
23. 70408	FORTIS BENEFITS INS CO	1.1%	(1.3%)	19,657	19,627	12,036	11,912	60.7%
24. 20443	CONTINENTAL CASUALTY CO	1.1%	(1.0%)	19,404	13,047	10,298	18,077	138.6%
25. 35106	NIAGARA FIRE INS CO	1.0%	(2.5%)	18,763	18,763	22,303	16,726	89.1%
	Total for Top 25:	64.7%		1,178,676	1,163,691	876,863	921,632	79.2%
	Total for 464 Insurers reporting:			1,822,742	1,804,598	1,370,123	1,427,134	79.1%

Company Names: CO = COMPANY CORP = CORPORATION INS = INSURANCE

Note: Due to rounding, numbers may not produce the totals presented.
Insurers Reporting may include insurers that did not have any written premiums but may have reported other activity such as Direct Premiums Earned, Dividends Paid, Losses Paid and Losses Incurred.

Total Arizona Premiums for This Line for All Insurers Reporting

($000 Omitted)



Attachment 3

10-15-03

ALL OTHER HEALTH CARE

2002 Ranking of Top Twenty-Five† Insurers by Premiums Written

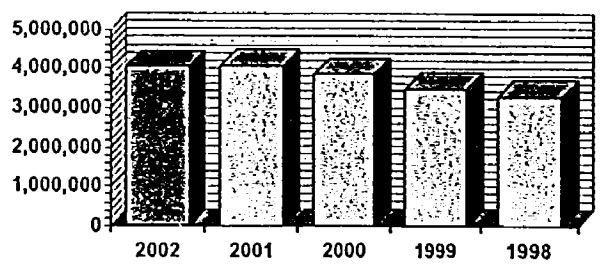
	NAIC#	INSURER NAME	Market Share '02	Market Share ('01)	PREMIUMS WRITTEN ($000's Omitted)	ARIZONA MEMBERS Units	INSURER TYPE
1.	95617	PACIFICARE OF ARIZONA, INC.	22.4%	(22.6%)	908,527	229,721	HCSO
2.	95125	CIGNA HEALTHCARE OF ARIZONA, INC.	20.2%	(14.9%)	818,029	267,840	HCSO
3.	53589	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.	18.5%	(15.4%)	751,869	770,142	SERVICE CORP
4.	95206	HEALTH NET OF ARIZONA, INC.	11.4%	(17.2%)	462,855	116,859	HCSO
5.	96016	UNITED HEALTHCARE OF ARIZONA, INC.	8.0%	(10.3%)	325,564	138,097	HCSO
6.	95003	AETNA HEALTH INC.	8.0%	(8.8%)	323,832	205,114	HCSO
7.	95885	HUMANA HEALTH PLAN, INC.	4.4%	(4.4%)	179,038	51,962	HCSO
8.	95982	SUN HEALTH MEDISUN, INC.	2.3%	(1.2%)	91,564	16,393	HCSO
9.	52637	MAYO HEALTH PLAN ARIZONA	1.7%	(1.7%)	67,743	30,200	SERVICE CORP
10.	53597	DELTA DENTAL PLAN OF ARIZONA, INC.	1.3%	(1.5%)	53,938	132,260	SERVICE CORP
11.	95797	ONE HEALTH PLAN OF ARIZONA, INC.	0.6%	(0.8%)	23,411	7,119	HCSO
12.	47013	CIGNA DENTAL HEALTH PLAN OF ARIZONA, INC.	0.5%	(0.5%)	18,915	108,964	PREPAID DENTAL
13.	53090	EMPLOYERS DENTAL SERVICES, INC.	0.4%	(0.3%)	14,553	150,298	PREPAID DENTAL
14.	47708	UNITED DENTAL CARE OF ARIZONA, INC.	0.3%	(0.4%)	12,213	114,710	PREPAID DENTAL
15.	52120	TOTAL DENTAL ADMINISTRATORS HEALTH PLAN, INC.	0.0%	(0.0%)	1,743	12,299	PREPAID DENTAL
16.	47012	SIGHTCARE, INC.	0.0%	(0.0%)	753	74,779	SERVICE CORP
17.	95224	PREMIER CHOICE DENTAL, INC.	0.0%	(0.0%)	410	9,337	PREPAID DENTAL
18.	95366	PRIVATE MEDICAL-CARE OF ARIZONA, INC.	0.0%	(0.0%)	268	970	PREPAID DENTAL
19.	52122	UNITED CONCORDIA DENTAL PLANS OF ARIZONA, INC.	0.0%	(0.0%)	158	1,207	PREPAID DENTAL
		Total for Top 25:	100.0%		4,055,382	2,438,271	
		Total for 19 Insurers reporting:			4,055,382	2,438,271	

Company Names: CO = COMPANY CORP = CORPORATION INS = INSURANCE

Note: Due to rounding, numbers may not produce the totals presented.
Insurers Reporting may include insurers that did not have any written premiums but may have reported other activity such as Arizona Members.
† There were only 19 of these Insurers reporting business in Arizona during Calendar Year 2002.

Total Arizona Premiums for This Line for All Insurers Reporting

($000 Omitted)



Attachment 24

10-15-03

2002 MARKET ANALYSIS SURVEY - Life and Disability *

Limited Benefit and Major Medical Policies

NAIC	Insurer Name	Major Medical Total	Limited Benefit Total**	Grand Total
79413	UNITED HEALTHCARE INSURANCE COMPANY	57,013	21,443	129,277
62308	CONNECTICUT GENERAL LIFE INSURANCE COMPANY	43,939	13,730	102,706
73288	HUMANA INSURANCE COMPANY	26,535	24,585	69,079
72052	CORPORATE HEALTH INSURANCE COMPANY	24,082	0	24,082
66141	HEALTH NET LIFE INSURANCE COMPANY	23,504	0	23,516
97055	MEGA LIFE AND HEALTH INSURANCE COMPANY, THE	12,238	3,785	19,687
97179	UNITED WISCONSIN LIFE INSURANCE COMPANY	11,875	3,347	15,222
69477	FORTIS INSURANCE COMPANY	10,626	1,240	15,359
60054	AETNA LIFE INSURANCE COMPANY	8,458	61,897	113,859
62286	GOLDEN RULE INSURANCE COMPANY	7,244	0	16,598
69744	UNION LABOR LIFE INSURANCE COMPANY	7,228	10,923	49,139
60305	AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	6,650	7,857	20,064
65080	JOHN ALDEN LIFE INSURANCE COMPANY	6,233	145	10,335
84506	PACIFICARE LIFE ASSURANCE COMPANY	5,886	6,498	18,883
61425	TRUSTMARK INSURANCE COMPANY	5,841	34,303	67,119
90611	ALLIANZ LIFE INSURANCE COMPANY OF NORTH AMERICA	5,166	28,984	57,074
67466	PACIFIC LIFE INSURANCE COMPANY	5,113	8,118	45,207
97268	PACIFIC LIFE & ANNUITY COMPANY	5,106	8,124	21,426
61271	PRINCIPAL LIFE INSURANCE COMPANY	5,060	74,672	110,592
69078	STANDARD SECURITY LIFE INSURANCE COMPANY OF NY	3,570	30	7,763
61557	CPIC LIFE INSURANCE COMPANY	3,395	176	6,654
66087	MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENN.	3,146	1,263	5,193
74217	MEDICAL SAVINGS INSURANCE COMPANY	3,055	0	3,055
71412	MUTUAL OF OMAHA INSURANCE COMPANY	2,823	35,148	50,603
60836	AMERICAN REPUBLIC INSURANCE COMPANY	2,155	182	9,836
81108	UNITED SECURITY LIFE INSURANCE COMPANY OF ILLINOIS	2,120	279	4,825
69868	UNITED OF OMAHA LIFE INSURANCE COMPANY	2,088	61,454	165,685
70408	FORTIS BENEFITS INSURANCE COMPANY	1,852	48,719	76,256
80926	GE GROUP LIFE ASSURANCE COMPANY	1,753	8,191	9,944
68322	GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY	1,283	7,875	27,427
64246	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	1,061	47,776	65,929
66915	NEW YORK LIFE INSURANCE COMPANY	988	5,743	98,612
70106	UNITED STATES LIFE INS. CO. IN THE CITY OF N. Y., THE	959	9,111	26,070
76112	OXFORD LIFE INSURANCE COMPANY	948	4	14,108
61727	CENTRAL RESERVE LIFE INSURANCE COMPANY	915	162	1,929
71404	CONTINENTAL GENERAL INSURANCE COMPANY	915	162	1,929
71773	AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS	736	25,958	26,753
62413	CONTINENTAL ASSURANCE COMPANY	728	20	20,211
65978	METROPOLITAN LIFE INSURANCE COMPANY	538	269,553	300,476
70629	WORLD INSURANCE COMPANY	510	70	828
62324	FREEDOM LIFE INSURANCE COMPANY OF AMERICA	488	304	801
91626	NEW ENGLAND LIFE INSURANCE COMPANY	405	259	1,058
80799	CELTIC INSURANCE COMPANY	377	0	396
82538	NATIONAL HEALTH INSURANCE COMPANY	358	16	842
66281	MONUMENTAL LIFE INSURANCE COMPANY	306	44,826	114,004
62553	COUNTRY LIFE INSURANCE COMPANY	303	714	12,009
67784	PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY	257	10	277
71870	FIDELITY SECURITY LIFE INSURANCE COMPANY	246	48,750	51,164
81264	NIPPON LIFE INSURANCE COMPANY OF AMERICA	132	201	399
60534	AMERICAN HERITAGE LIFE INSURANCE COMPANY	125	5,446	6,177
80578	PHYSICIANS MUTUAL INSURANCE COMPANY	124	6,580	10,293
62944	EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES	119	808	32,163
64130	LIFE INVESTORS INSURANCE COMPANY OF AMERICA	96	1,576	22,229

* Policy counts reported by insurers are not verified.

** Limited Benefit plans include: vision or dental-only, disability income, hospital indemnity, or specified disease.

Attachment 5 1
10-15-02

September, 2003

ARIZONA ACCOUNTABLE HEALTH PLANS

(Companies Authorized to Sell Group Health Insurance)

1. Aetna Life Insurance Company
2. Aetna U.S. Healthcare, Inc.
3. Allianz Life Insurance Company of North America
4. Alta Health & Life Insurance Company
5. American Community Mutual Insurance Company
6. Avemco Insurance Company
7. Benchmark Insurance Company
8. BEST Life and Health Insurance Company
9. Blue Cross/Blue Shield of Arizona, Inc.
10. Cambridge Life Insurance Company
11. Central Reserve Life Insurance Company
12. CIGNA Healthcare of Arizona, Inc.
13. Connecticut General Life Insurance Company
14. Continental Assurance Company
15. Corporate Health Insurance Company
16. Fidelity Security Life Insurance Company
17. Fortis Benefits Insurance Company
18. Fortis Insurance Company
19. Foundation Health Systems Life & Health Insurance Company
    dba Health Net Life Insurance Company
20. GE Group Life Assurance Company
    formerly Phoenix American Life Insurance Company
21. Great-West Life & Annuity Insurance Company
22. Health Net of Arizona, Inc.
    formerly Intergroup Prepaid Health Services of Arizona, Inc.
23. Humana Health Plan, Inc.
24. Humana Insurance Company
25. John Alden Life Insurance Company
26. MEGA Life and Health Insurance Company (The)
27. Metropolitan Life Insurance Company
28. Mid-West National Life Insurance Company of Tennessee
29. Monumental Life Insurance Company
30. National Health Insurance Company
31. New England Life Insurance Company
32. One Health Plan of Arizona, Inc.
33. Pacific Life & Annuity Company

Attachment 6

10-15-03

ARIZONA ACCOUNTABLE HEALTH PLANS

(Companies Authorized to Sell Group Health Insurance)

34. Pacificare Life Assurance Company
35. PacifiCare of Arizona, Inc.
36. Pan-American Life Insurance Company
37. Principal Life Insurance Company
38. ReliaStar Life Insurance Company
39. State Farm Mutual Automobile Insurance Company
40. Trustmark Insurance Company
41. United HealthCare Insurance Company
42. United HealthCare of Arizona, Inc.
43. United Security Life Insurance Company of Illinois
44. United States Life Insurance Company of New York (The)
45. United Wisconsin Life Insurance Company
46. Washington National Insurance Company

SMALL GROUP PREMIUM AND TAX EXEMPT DATA FROM PREMIUM TAX REPORTS

YEAR	SMALL GROUP PREMIUM	TAX RATE % EXEMPTION	TOTAL TAXES EXEMPT
1996	$110,149,153	1.00%	1,101,492
1997	$280,216,533	1.50%	4,203,248
1998	$309,114,318	2.00%	6,182,286
1999	$389,732,050	2.00%	7,794,641
2000	$460,846,488	2.00%	9,216,930
2001	$505,881,905	2.00%	10,117,638
2002	$597,632,140	2.00%	11,952,643
TOTAL	$2,653,572,587		50,568,878

NOTES: (1) THE PREMIUM AMOUNTS SHOWN ARE THE TOTAL EXEMPTIONS FOR THE YEAR LISTED. THESE ARE THE AMOUNTS AFTER ADJUSTING THE 1996 AND 1997 PREMIUMS TO SHOW ONLY THE EXEMPTED PORTION.
(2) IN 1996 THE EXEMPTION WAS 1% BEGINNING JULY 1, 1996.
(3) IN 1997 THE EXEMPTION WAS 1% TO JULY 1, 1997 AND 2% THEREAFTER.

D

Attachment 7

10-15-03

REFERENCE TITLE: Mandatory Health Insurance

Arizona Silver Haired Legislature

ASHL 0311

Introduced by
Delegate Marie Wells

A RESOLUTION

MANDATORY HEALTH INSURANCE

Be it resolved by the Arizona Silver Haired Legislature:

Whereas, In the 1998 census Arizona showed 1,187,000 people lacked health insurance; and

Whereas, Arizona will be discontinuing the state's Premium Sharing program in September, 2003 which helped the uninsurable, (e.g. diabetics), to obtain health insurance based on their income; and

Whereas, In 1999 only 44% had employer-based coverage in urban areas, and 31% in rural areas.

Therefore, Be it resolved by the Arizona Silver Haired Legislature urge that Arizona law requires employers in Arizona with over ~~20~~ 50 employees be required to offer health insurance to all temporary, part-time, and full-time employees 19 years of age or older that work 15 or more hours per week, after three months of employment.

Attachment 8

THE ARIZO

TUESDAY • SEPTEMBER 30, 2003

Uninsured rate rises in state, U.S.

1 million Arizonans without health care

By Jon Kamman
and Hal Mattern
The Arizona Republic

Nearly 1 million Arizonans had no health insurance for at least one of the past two years, the Census Bureau reported Monday.

That's an increase of more than 30,000 from the previous estimate despite a massive increase in enrollment in the insurance program under which the state delivers Medicaid services.

Still, if holding relatively steady in its rate of uninsured can be considered an accomplishment against a backdrop of a 2.3 million surge nationally, Arizona fared well.

Across the country, 18 states posted significant increases in uninsured, 31 stayed about the same, and only one, New Mexico, showed improvement.

Arizona's uninsured rate

See UNINSURED Page

Until she was severely ... never imagined she would ...

Medical center's fate is in hands of voters

...alded, Linda Angeloff of Scottsdale ... need the Arizona Burn Center

By Christina Leonard
The Arizona Republic

Maricopa County officials are asking voters to approve a new property tax to help support the system that provides health care to the county's poor and uninsured ...

Proposition 414 would raise up to $40 million a year and create a special health care district aimed at shoring up finances and renovating facilities at Maricopa Medical Center ...

Valley hospitals ... uninsured patients ...

UNINSURED 'Horrendo

From Page A1

was 17.4 percent, not statistically different from 17.3 percent earlier. The figure meant that on average, more than one in six Arizonans had no medical coverage in 2001-02.

In an ironic illustration of the breadth of Arizonans' health insurance needs, the Arizona Health Care Cost Containment System has 966,000 enrollees, barely more than the 950,000 people still without insurance in the state.

Frank Lopez, spokesman for the program, said AHCCCS enrollment has increased about 75 percent since Proposition 204 went into effect in 2001. The measure required that the state's tobacco-litigation revenue be spent on medical services for anyone at or below the official poverty level.

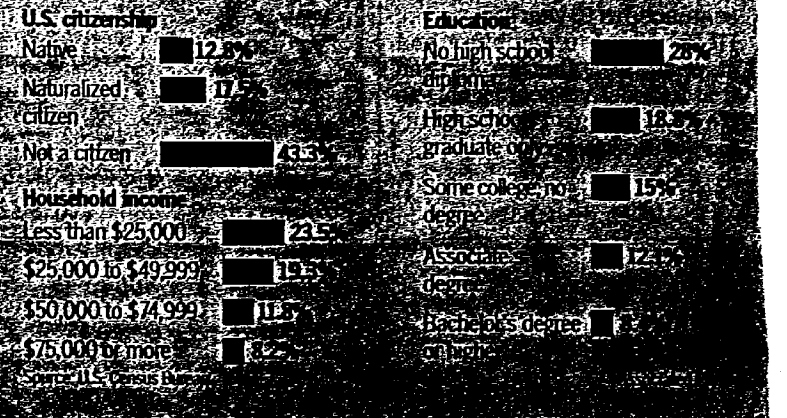
A slumping economy that has produced both higher unemployment and a cutoff of health care coverage by many employers bears most of the blame for the jump in the uninsured rate, analysts said.

Ten years ago, two-thirds of all workers were covered by employer-backed insurance plans, said John Rivers, chief executive officer of Arizona Hospital and Health Care Association. The latest figure, [illegible] that it has dropped below 60 percent. [illegible]

Nearly half of uninsured are non-citizens

Overall, the percentage of people without health insurance rose from 14.6 percent in 2001 to 15.2 percent in 2002. A loss of work-based coverage stemming from layoffs and scaled-back benefits primarily was to blame.

CHARACTERISTICS OF UNINSURED, 2002



Source: U.S. Census Bureau

ous economy a factor

ployer-sponsored coverage is declining for at least three reasons," he said, transfer of American manufacturing jobs overseas, rising health insurance premiums and the weak economy.

"It's been a horrendous economy," Lopez said. "When that happens, our business goes up."

Kris Mayes, spokeswoman for Gov. Janet Napolitano, said the governor is "concerned about the number [illegible]

"Were it not for the proposition expanding AHCCCS, the numbers ... would be even worse," she said.

"It shows we need to redouble our efforts at economic development, because people who have good jobs [illegible] health insurance," Mayes said.

Nationwide, the uninsured rate rose to 15.2 percent in 2002, from 14.6 percent the previous year.

The increase pushed the number of uninsured individuals to 43.8 million.

Breakdowns by race and ethnic group were available only on the national level.

Although the rate for Hispanics dipped slightly, the group still had the highest uninsured rate, 32.4 percent, or nearly one-third of the nation's 39 million Latinos.

The rate for Blacks [illegible] population is slightly [illegible] than Hispanics, [illegible] 19.9 percent, or about one in five, from 19 percent in 2001.

Nationwide, about 43 [illegible] cent of the uninsured [illegible] citizens. No figure [illegible] available.

Lopez said [illegible] immigrants in Arizona [illegible] provided [illegible] health care, [illegible] the number [illegible] treated, [illegible] averages [illegible] including [illegible]

Because of [illegible] sampling size, statisticians [illegible] an average [illegible] year periods, unlike the year-to-year calculations for the nation as a whole.

Arizona's overall performance in 2001-02 ranked the state behind 33 other states, but the Census Bureau said 12 other states registered roughly the same rate as Arizona once the survey's margin of error was taken into account.

Texas ranked [illegible] the nation [illegible] 24 percent, [illegible] about one-fourth [illegible] people uninsured.

California [illegible] cent rate [illegible] zona's.

[illegible] been in the last [illegible] of whites [illegible] percentage point [illegible] 20[illegible] with 20[illegible] percent uninsured.

Reach the reporter [illegible] Jon.Lamman@arizonarepublic.com or (602) 444-[illegible]

SEPT 3 [illegible] 2003 - AZ REP [illegible]

Plight of uninsured moves to middle class

Growing hardships make health care a politically explosive issue

ANALYSIS

By Robin Toner
New York Times

WASHINGTON — The jump in the number of Americans without health insurance is not just another bad economic statistic.

Health care costs are soaring again, after several years of stability; average premiums rose nearly 14 percent this year, the third year of double-digit increases, according to the Kaiser Family Foundation.

Employers are pushing more of the costs onto their workers, raising co-payments and deductibles. At the same time, many Americans saw their health benefits jeopardized by layoffs, which have continued despite the official end of the recession in November 2001.

In such times, the uninsured becomes more of a middle-class issue, more of a symbol of real, close-to-home insecurity, and thus more politically potent, many advocates and analysts say.

"Until now, it's mainly been an issue of altruism for a discrete and disadvantaged population," said Ron Pollack, executive director of Families USA, a liberal consumer advocacy group. "Now that the losses in health coverage are impacting more middle-class and working families, this issue becomes one of self-interest for a very substantial part of the population."

Even before the Census Bureau announced the new figures showing that the number of uninsured Americans had risen by 2.4 million last year to 43.8 million, most of the major Democratic presidential candidates were campaigning [illegible] the 1992 election has the issue drawn so much attention, and the reasons are not hard to find.

For Democrats, it is a powerful symbol of a sluggish economy, of a lack of federal money to deal with domestic problems because of the deficit and the war in Iraq, and of what they say is the Bush administration's insensitivity to the needs of the home front. It could, in short, be a significant vulnerability for President Bush if the Democrats succeed in framing this election as a referendum on domestic policy.

Republicans argue that the administration has several major initiatives on the table to deal with the problems of cost and access to health care, from its Medicare prescription drug plan to legislation that would cap jury awards in medic[illegible] obstructing that process, that could be a significant problem for them politically," said Christine Iverson, a spokeswoman for the Republican National Committee.

The Bush administration has also proposed in the past to expand coverage to the uninsured through the use of tax credits to help them buy insurance. Still, some analysts say the administration eventually will have to offer a broader vision on health care as an alternative to the Democrats.

In fact, Americans place the health care issue high on the political agenda, based on recent polls. A CNN/*USA Today*/Gallup poll last week found that a candidate's position on health care was cited as "extremely important" by 43 percent of Americans, just below terrorism (cited by 49 percent) and the economy (49 percent), and well above the environment (30 percent) and taxes (36 percent).

An NBC News/*Wall Street Journal* poll in July found that health care costs ranked at the top of Americans' economic concerns, cited by 24 percent, compared with 16 percent who cited high taxes.

Most of the Democratic candidates have produced [illegible] plans to expand health coverage, generally financing them by rolling back all or part of Bush's tax cuts. But Republican strategists are quick to point out that the politics of health care are complicated, and the candidate with the biggest plan is not always rewarded.

The classic example, of course, is President Clinton, who successfully ran on the promise of universal health care only to see his plan for national health insurance turn into a political and legislative debacle.

Critics said the Clinton plan would cost more, create a huge new bureaucracy and give many Americans poorer health coverage than they already had.

Given the Democrats' reliance on using the tax cut to finance a health care plan, Republicans are very likely to make a version of that argument again.

Bill McInturff, a Republican pollster and longtime expert on public opinion and health, said: "A lot of [illegible] right about who [illegible] pays, who is perceived to get the benefit [illegible] middle-income voters [illegible] they are being asked to pay more so that others get health care, political paralysis [illegible] happened [illegible]."

In fact, the problems in the health care system are related to nearly every issue bubbling domestically, from unemployment to the fiscal crisis in the states. Moreover, even if employment begins to [illegible] new estimates will be released Friday — no one is expecting a speedy turnaround in the problems of health care costs and coverage.

USA TODAY SEPT 30th 2003

43.6 million don't have health insurance

By Julie Appleby
USA TODAY

The number of U.S. residents without health insurance rose at the fastest clip in a decade last year, hitting 43.6 million, a development expected to increase pressure on lawmakers to take strong action to ease the problem.

About 15% of the population was without insurance in 2002, Census Bureau figures released today show. The number of uninsured grew by 2.4 million, the largest increase since 1991-92. When 3.2 million lost coverage in 2001. Many of those people lost their jobs and their insurance because of the struggling economy. For some, insurance was lost when double-digit premium increases caused employers to stop offering coverage. Some of the uninsured opted not to enroll in coverage offered by employers, as the amount taken from their paychecks to cover the cost rose.

Slowing the increase in the uninsured last year was a rise in the number of residents enrolled in Medicaid, the federal/state health program for the poor. The number of uninsured children fell, reflecting an effort to enroll eligible low-income children in government health plans. Overall, the number of residents with insurance rose by 1.5 million, mainly due to population growth. This year, many state Medicaid programs are facing cuts and adult enrollees are being dropped from coverage.

emergency rooms and clinics across the county is any indication, my fear is the 2003 figures will be far worse," Michael Place, president and CEO of the Catholic Health Association of the United States, an association of Catholic hospitals, clinics and health plans. Member hospitals report a steady increase in patients without insurance or without adequate coverage.

The rapid rise in the number of uninsured means lawmakers will feel pressure from constituents who are worried about losing coverage, says Paul Ginsburg, president of the Center for Studying Health System Change, a nonpartisan research group in Washington. He expects lawmakers will consider more far-reaching proposals than those of recent years. "Incremental change is dead for now."

The Bush administration has called for increased funding for health clinics and a tax credit for low- and moderate-income residents to help offset the cost of buying health insurance. Presidential candidates have suggested a range of plans, many of which would expand existing government health programs.

The largest increase in the uninsured — a jump of 1.1 million — came in households earning $25,000 to $49,999 a year. The next-largest jump, 633,000, came in households with incomes of $75,000 or more. The smallest jump was among households with less than $25,000 in income, the group most likely eligible for government aid. Still, the lowest-income group represents the largest total number of uninsured.

BIG INCREASE SEEN IN PEOPLE LACKING HEALTH INSURANCE

LARGEST RISE IN A DECADE

Higher Costs and a Decline in Workplace Coverage Are at Fault, Census Finds

By ROBERT PEAR

WASHINGTON, Sept. 29 — The number of people without health insurance shot up last year by 2.4 million, the largest increase in a decade, raising the total to 43.6 million, as health costs soared and many workers lost coverage provided by employers, the Census Bureau reported today.

The increase brought the proportion of people who were uninsured to 15.2 percent, from 14.6 percent in 2001. The figure remained lower than the recent peak of 16.3 percent in 1998.

A continued erosion of employer-sponsored coverage was the main reason for the latest increase, the bureau said. Public programs, especially Medicaid, covered more people and cushioned the loss of employer-sponsored health insurance, but not enough to offset the decline in private coverage, the report said.

The proportion of Americans with insurance from employers declined to 61.3 percent, from 62.6 percent in 2001 and 63.6 percent in 2000. The number of people with employer-sponsored coverage fell last year by 1.4 million, to 175.3 million, even as the total population grew by 2.9 million.

Tommy G. Thompson, the Secretary of health and human services, said the numbers showed that the nation must do more to help the uninsured. Mr. Thompson said, for example, that Congress should provide tax credits for the purchase of private insurance.

But no action is imminent. Congress is preoccupied with efforts to help a large, politically potent group that already has insurance, the elderly.

A continued erosion of employer-sponsored coverage.

pared with 13 percent in the Northeast, 17.1 percent in the West and 17.5 percent in the South.

As an entitlement program, Medicaid expands to meet the need in hard economic times.

Despite the Medicaid program, 10.5 million poor people, or 30.4 percent of those in poverty, had no health insurance last year. This percentage, double the rate for the total population, did not change from the prior year. About 24 percent of all uninsured people were poor.

The proportion of blacks and non-Hispanic whites without health insurance rose last year, to 20.2 percent and 10.7 percent, respectively. The figure for Hispanics was much higher, 32.4 percent, unchanged from the prior year.

Fully one-third of the foreign-born population was uninsured. About 43 percent of noncitizens — 8.9 million of the 20.6 million noncitizens — and 17.5 percent of naturalized citizens lacked coverage.

Among people living in poverty, 49 percent of those who worked full time were uninsured.

But middle-income households accounted for most of the increase in the number of uninsured. In households with annual incomes of $25,000 to $74,999, the number of uninsured people rose last year by 1.4 million, to 21.5 million, and the increase was most noticeable among households with incomes of $25,000 to $49,999.

At companies with fewer than 25 employees, only 30.3 percent of the workers had employer-sponsored insurance in their own names last year, down from 31.3 percent in 2001. The proportion of workers with insurance also declined at companies with 25 to 99 employees (by 2.4 percentage points, to 54.4 percent) and even at businesses with more than 1,000 employees (by nine-tenths of a percentage point, to 68.7 percent).

Senator Max Baucus, Democrat of

Health Care Coverage Down For a 2nd Year, Census Finds

Continued From Page A1

number of uninsured was likely to rise this year because the job market remains weak and many states have cut back their Medicaid programs. The unemployment rate was higher in 2002 than in 2001 and has climbed a bit further this year.

Hanns Kuttner, a health policy analyst at the University of Michigan, said: "Rising rates of unemployment tend to erode health insurance coverage among adults. But when parents lose jobs, their children are more likely to be eligible for public programs."

About 8.5 million children were uninsured in 2002. They account for 11.6 percent of all children under 18. Both numbers were virtually the same as in 2000 and 2001.

Genevieve M. Kenney, an economist at the Urban Institute here, said: "Programs intended to provide coverage for children are working to compensate for the economic downturn and catching a lot of kids who would otherwise be uninsured. But many states, in the midst of a fiscal crisis, have reduced efforts to locate and enroll children eligible for Medicaid."

Men are more likely to be uninsured than women. Men accounted for two-thirds of the increase in the number of uninsured, apparently because they were more likely to lose employer-sponsored coverage.

The number of uninsured men rose by 1.6 million last year, to 23.3 million, while the number of uninsured women rose by 761,000, to 20.2 million.

The drop in coverage came even though the number of people with health insurance increased by 1.5 million last year, to 242.4 million. But the increase was more than offset by the combined effects of population growth and the decline in workplace coverage.

The proportion of people without health insurance ranged from 8 percent in Minnesota to 24.1 percent in Texas. The rates for Rhode Island, Wisconsin and Iowa, which have made sustained efforts to expand coverage, were similar to the figure in Minnesota.

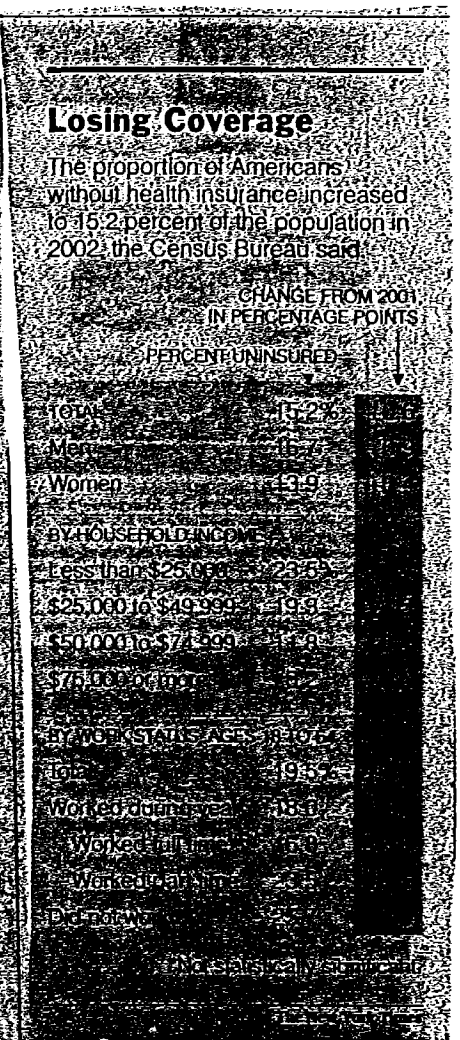
Texas, facing fiscal problems and unwilling to raise taxes, cut back Medicaid and its Children's Health Insurance Program this year.

Looking at two-year averages, the Census Bureau said that the proportion of people without coverage fell in New Mexico but rose in 18 states, Colorado, Idaho, Indiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Virginia and Wisconsin. The changes in the other states were not statistically significant.

People in the South and the West were more likely to be uninsured. Only 11.7 percent of people in the Middle West were uninsured, com-

Losing Coverage

The proportion of Americans without health insurance increased to 15.2 percent of the population in 2002, the Census Bureau said.



Montana, said he was working with Senator Charles E. Grassley, Republican of Iowa, on a bill that would offer tax credits to help workers pay for certain health insurance.

"We have long known the problem of the uninsured," Mr. Baucus said. "This year's data show that it's getting worse."

NEW YORK TIMES SEPT 30 2003

Boiling Brew: Politics and Health Insurance Gap

By ROBIN TONER

WASHINGTON, Sept. 29 — The jump in the number of Americans without health insurance is not just another bad economic statistic.

Health care costs are soaring again, after several years of stability; average premiums rose nearly 14 percent this year, the third year of double-digit increases, according to the Kaiser Family Foundation. Employers are pushing more of the costs onto their workers, raising copayments and deductibles. At the same time, many Americans saw their health benefits jeopardized by layoffs, which have continued despite the official end of the recession in November 2001.

In such times, the plight of the uninsured becomes more of a middle-class issue, more of a symbol of real, close-to-home insecurity, and thus more politically potent, many advocates and analysts say. Until now, "it's mainly been an issue of altruism for a discrete and disadvantaged population," said Ron Pollack, executive director of Families USA, a liberal consumer advocacy group. "Now that the losses in health coverage are impacting more middle-class and working families, this issue becomes one of self-interest for a very substantial part of the population."

Even before the Census Bureau announced the new numbers, showing that the number of uninsured Americans had risen by 2.4 million last year, to 43.6 million, most of the major Democratic presidential candidates were campaigning hard on the problems in the health care system. Not since the 1992 election has the issue drawn so much attention, and the reasons are not hard to find.

For Democrats, it is a powerful symbol of a sluggish economy, of a lack of federal money to deal with domestic problems because of the deficit and the war in Iraq, and of what they say is the Bush administration's insensitivity to the needs of the home front. It could, in short, be a significant vulnerability for President Bush — if the Democrats succeed in framing this election as a referendum on domestic policy.

Republicans argue that the administration has several major initiatives on the table to deal with the problems of cost and access to health care, from its Medicare prescription drug plan to legislation that would cap jury awards in medical malpractice lawsuits.

"If Democrats are seen as obstructing that process, that could be a significant problem for them politically," said Christine Iverson, a spokeswoman for the Republican National Committee.

The Bush administration has also proposed in the past to expand coverage to the uninsured through the use of tax credits to help them buy insurance. Still, some analysts say the administration will eventually have to offer a broader vision on health care as an alternative to the Democrats.

In fact, Americans place the health care issue high on the political agenda, based on recent polls. A CNN/USA Today/Gallup Poll last week found that a candidate's position on health care was cited as "extremely important" by 43 percent of Americans, just below terrorism (cited by 49 percent) and the economy (49 percent), and well above the environment (30 percent) and taxes (36 percent).

An NBC News/Wall Street Journal poll in July found that health care costs ranked at the top of Americans' economic concerns, cited by 24 percent, compared with 16 percent who cited high taxes.

> When the middle class worries, so do politicians.

Most of the major Democratic candidates have produced a major plan to expand health coverage, generally financing it by rolling back all or part of Mr. Bush's tax cuts. But Republican strategists are quick to point out that the politics of health care are complicated, and the candidate with the biggest plan is not always rewarded.

The classic example, of course, is President Bill Clinton, who successfully ran on the promise of universal health care only to see his actual plan for national health insurance turn into a political and legislative debacle. Critics said the Clinton plan would cost more, create a huge new government bureaucracy and give many Americans poorer health coverage than they already had.

Given the Democrats' reliance on using the tax cut to finance a health care plan, Republicans are very likely to make a version of that argument again. Bill McInturff, a Republican pollster and longtime expert on public opinion and health, said, "A lot of 2004 will be a fight about who is perceived to pay versus who is perceived to get the benefit." In the past, when middle-income voters sense they are being asked to pay more so that others get health care, "political paralysis has happened," he said.

Still, Mr. McInturff added, "People still don't get how big an issue this will be. The numbers and the state of the economy and the relationship between the cost of care and what's happened to the uninsured will be addressed in the 2004 campaign cycle, because it's what people care about."

In fact, the problems in the health care system are related to nearly every issue bubbling domestically, from unemployment to the fiscal crisis in the states. Moreover, even if employment begins to pick up — and new estimates will be released on Friday — nobody is expecting a speedy turnaround in the problems of health care costs and coverage.

(A)

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THE SAN DIEGO UNION-TRIBUNE

PRINT THIS

New state law to require health coverage

1 million workers expected to benefit; businesses decry costs

By Bill Ainsworth
UNION-TRIBUNE STAFF WRITER

October 6, 2003

SACRAMENTO – Gov. Gray Davis signed a bill yesterday that takes a major step toward reducing the ranks of the uninsured, making California a national leader in expanding health insurance.

Associated Press
California Gov. Gray Davis takes notes before signing a pair of health care bills at Kaiser Permanente Medical Center in West Los Angeles.

The program will cover about 1 million of the 6 million uninsured Californians by requiring larger companies to provide health insurance for their employees or pay a fee into a state fund that will provide coverage for the workers.

The measure was one of the more contentious bills in the Legislature this year, with businesses decrying the costs and health care advocates rallying for the expanded coverage.

The costs for businesses have yet to be determined, but estimates put it in the range of $1,300 to $3,500 per employee annually.

"Today, California takes a bold and balanced step forward to reform health care," Davis said during a ceremony in Los Angeles where supporters held "No Recall" signs.

He was joined by the Rev. Jesse Jackson, actor Danny Glover, several lawmakers and other backers of the bill.

Among the leading replacement candidates in the recall election, Democratic Lt. Gov. Cruz Bustamante supports the new plan, and Republicans Arnold Schwarzenegger and state Sen. Tom McClintock of Thousand Oaks oppose it.

Supporters, including the California Medical Association, say the bill will improve the quality of life for 1 million uninsured people.

The measure "establishes the principle that if you work hard and pay taxes, you should get health care," said Art Pulaski, head of the California Labor Federation, AFL-CIO, a backer of the bill and a supporter of Davis' effort to survive tomorrow's recall election.

According to the state Employment Development Department, 95 percent of employers have fewer than 50 employees and are exempt from the new law. Further, most large employers already pay health insurance.

Firms that don't cover employees' health insurance are most often in retail sales, construction or the restaurant industry. A survey by the Institute for Labor and Employment at the University of California Berkeley found that 64 percent of private businesses favor the plan.

Small-business owner Bobbi Kimball, who operates House Calls Home Health Agency in Stockton, said she pays insurance for 35 workers and backs the legislation.

"If I can do it, they can do it," she said. "If we have to force people to be generous, that's too bad."

Health care advocates say the bill is the largest expansion of health care since the federal government passed a plan to insure children of the working poor in the mid-1990s. In California the plan, called Healthy Families, was implemented in 1998.

(A-1)

Employers expected to fight new worker health insurance law

Lynda Gledhill, Christian Berthelsen, Chronicle Sacramento Bureau
Monday, October 6, 2003

URL: sfgate.com/article.cgi?file=/chronicle/archive/2003/10/06/MN285004.DTL

Sacramento -- Gov. Gray Davis on Sunday signed into law a sweeping health care bill that will require many employers to provide insurance for their workers, but opponents are already working to make sure it never takes effect.

Supporters of the law believe it will provide health insurance to nearly 1. 1 million working Californians now without coverage. Employers would be required to pay up to 80 percent of the cost, while employees would foot the rest of the bill.

While small businesses are exempt, some believe the bill -- known as SB2 -- could cost California companies as much as $14.2 billion and thousands of jobs.

Opponents plan to file paperwork in the next couple of days to start a referendum that would block the law.

"This bill is a multibillion dollar mandate that is a deterrent to job creation," said Richard Costigan, vice president of the California Chamber of Commerce. "But we're worried that this is just the tip of the iceberg. In order to pay for SB2, companies are going to have to lay people off, delay expansion, and look to relocate."

But in signing the bill in Los Angles, Davis lauded it as another way California leads the nation.

"Today we take a bold step to reform health care," Davis said at a ceremony attended by the Rev. Jesse Jackson, actor Danny Glover and labor leaders.

The bill was labor's top priority for the legislative year, and Davis signed it just two days before the state's historic recall election. Labor has been Davis' principal ally against the recall.

The governor noted that 50 percent of personal bankruptcies in California are related to people who go broke paying for health care, and that 80 percent of the uninsured in California are workers and the families of workers. He said the new law would go a long way toward providing coverage for them.

"These are citizens who do exactly what we ask them to do," he said. "They work hard, they play by the rules, and when they go to bed at night, they should have the peace of mind of knowing they can see a doctor if they get sick."

Businesses with 20 or fewer employees would be exempt. Companies with more than 200 employees would also have to provide insurance for employees' dependents.

Costigan said opponents to the measure have not decided whether to pursue the referendum

or go straight to legal challenges. But they will file the paperwork immediately, to preserve that option.

Opponents of the law would have 90 days to gather 373,816 valid signatures to get a referendum on the ballot. The law would be stayed until the vote is held.

But there is widespread popular support for the health care measure, said Peter Warren of the California Medical Association. He cited a poll showing that SB2 is backed by 63 percent of Californians.

Costigan said legal action could be pursued on two fronts -- both in state and federal court. The Chamber of Commerce believes the bill constitutes a tax on both the companies and the employees, and therefore it should have obtained a two-thirds vote to pass the Legislature.

Because there is no direct tax in the bill, it was approved on a simple majority vote, with only Democrats supporting it.

The chamber also believes the law is pre-empted by federal statutes and could be overturned in federal court.

At the Los Angeles ceremony, Chris Mackin, vice chair of the unionized, employee-owned Los Angeles firm Team X, a garment factory which uses the slogan "clothes with a conscience," said the new law would actually create a level playing field for businesses.

"As a businessman, I believe in competing on other things than the health care of my workers," he said. "I want to compete on quality . . . not on the backs of workers."

HEALTH INSURANCE ACT OF 2003

Who's covered: At least a million people who work in companies with 20 employees or more. The bill would require employers to pay for 80 percent of health care coverage. Employees would pay the remaining 20 percent, but low- wage workers would pay no more than 5 percent of their wages.

When it takes effect: Jan. 1, 2006, for companies with 200 or more employees; Jan. 1, 2007, for companies with 50 to 199 employees.

What it would cost: Estimates range from $1.3 billion to $7 billion annually for California businesses. Businesses would have the option to provide health coverage or pay a fee to the state, which would obtain coverage.

What's next: Possible legal challenge from business groups and a possible voter referendum to overturn the law.

E-mail Lynda Gledhill at lgledhill@sfchronicle.com.

(B)

Assigned to **GOV** FOR COMMITTEE

ARIZONA STATE SENATE

Phoenix, Arizona

FACT SHEET FOR S.B. 1100
health benefits; small employers

Purpose

Requires the Department of Administration (DOA) to generate a report on the feasibility of a health and dental insurance buy-in program for small businesses. Transfers $25,000 to DOA from the Personnel Division Fund for FY 1997-1998 to defray the costs associated with generating the report.

Background

The special report, Arizonans Without Health Insurance, issued October 1996, revealed that 15 per cent of Arizona adults and children (approximately 600,000 individuals) are without any form of health insurance. An identical study conducted by Louis Harris & Associates in 1989 reported that approximately 13 per cent (about 450,000) of all Arizonans were uninsured. Based upon these numbers, in the six year period between 1989 and 1996, the number of uninsured in Arizona increased by 33 per cent, out pacing the states estimated population growth of 21 per cent.

The Flinn Foundation (in a 1990 supplement to its Harris Poll survey on insurance in Arizona) reported that the majority of uninsured Arizonans live in Maricopa and Pima Counties. Flinn's figures also indicate that while the unemployed are more likely to be uninsured, nearly eight out of ten of Arizona's uninsured are employed or dependent on an employed adult.

Provisions

1. Requires DOA to prepare

C veringtheUninsured.org Printable Fact Sheet

How Many People Lack Health Coverage In the U.S.?

The U.S. spent $1.4 trillion on health care in 2001, yet 41.2 million Americans lacked basic health coverage.

- For most of the past 16 years, the number of people without health insurance has been on the rise.
- Although the number of uninsured declined between 1998 and 2000, that number is on the rise again because of a weakened economy and layoffs at many companies. Currently, some 41.2 million Americans lack health coverage, up 1.4 million from 2000. This includes 8.5 million children.

Who Are The Uninsured?

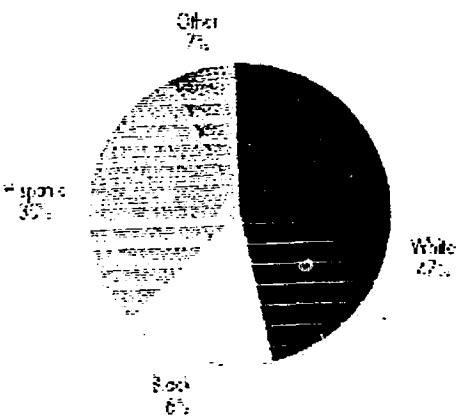
There are **41.2 million** uninsured:

19.4 million are non-Hispanic White
12.4 million are Hispanic
6.8 million are Black
2.3 million are Asian and Pacific Islander

(Source: Census Bureau, September 2002)

Note: There are at least seven major surveys that reflect the national picture of the uninsured in the U.S., with estimates ranging from 19 million to 42.6 million. The Current Population Survey, conducted by the U.S. Bureau of the Census, is the most widely used source of data on the uninsured. The most recently released CPS estimates indicate that 41.2 million people lacked health insurance coverage for the entire year in 2001.

Nonelderly Uninsured Population, by Race and Ethnic Origin, 2001



Source:Employee Benefit Research Institute estimates from the March Current Population Survey, 2002 Supplement.

Note: Estimates provided by the Census Bureau are slightly different than those provided by EBRI, as EBRI's analysis excludes Medicare beneficiaries and active-duty military.

from state to state.

Income Breakdown of the Uninsured

- 10.1 million uninsured people have family incomes at or below the federal poverty level; this group comprises a quarter of all uninsured people
- 14.5 million have incomes under $25,000
- 13.5 million have incomes between $25,000 and $49,999
- 6.6 million have incomes between $50,000 and $74,999
- 6.6 million have incomes that are at least $75,000

Here is a breakdown of average policy prices:

- The annual total cost for an average health policy at work was $2,426 for an individual and $7,035 for a family policy in 2000.
- The average premium paid directly by employee for employer-based insurance was $28 a month for individual coverage and $138 a month for family coverage in 2000.
- A non-group policy for a family typically costs more than employment-based insurance and/or provides poorer benefits.

Links

- Institute of Medicine, see "Coverage Matters: Insurance and Health Care,"
- Employee Benefit Research Institute
- Kaiser Family Foundation
- Economic and Social Research Institute

Sources

"Employer Health Benefits; 2001 Annual Survey." (2001) Kaiser Family Foundation and Health Research and Educational Trust.

Covering America: Real Remedies for the Uninsured. (June 2001) Economic and Social Research Institute.

Cunningham, Peter. "Who Declines Employer-Sponsored Health Insurance and Is Uninsured." (October 1999) Center for Studying Health System Change.

"Coverage Matters: Insurance and Health Care." (September 2001) Institute of Medicine.

Strunk, Bradley, Reschovsky, James D., "Working Families' Health Insurance Coverage, 1997-2001," Center for Studying Health System Change, Tracking Report No. 4, August 2002.

"Health Insurance is a Family Matter." (September 2002) Institute of Medicine.

CoveringtheUninsured.org Printable Fact Sheet

Who Are the Uninsured?

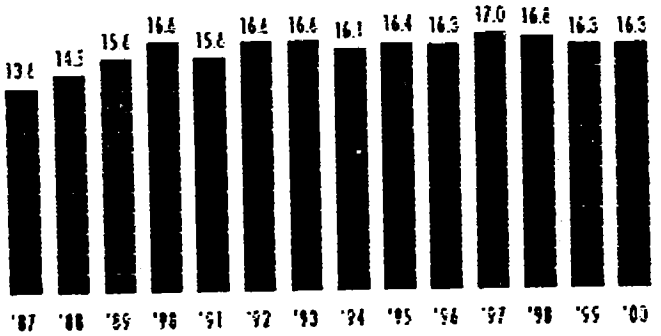
"My patients are hard-working people who often hold not one but as many as three jobs to pay their bills, clothe their children, and put food on the table. Most of them earn just enough to be ineligible for Medicaid ...They are forced to decide between paying rent and getting the health care they need."
- Margaret Pereyda, a physician in California

Key Facts

- The uninsured represent 14.6 percent of the population
- Eight out of 10 uninsured Americans are from working families
- Uninsured Americans come from every race, age and ethnic group
- Nearly a quarter of them are children

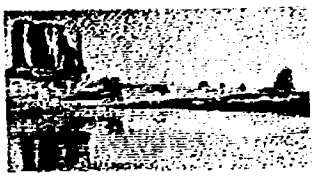
There are many myths about the uninsured. Many people believe, for example, that the majority of people who don't have health insurance are unemployed or choose not to buy health insurance for reasons related to their lifestyle. However, the uninsured come from different ages and ethnicities, and the majority of uninsured Americans work.

Percentage of Workers, Ages 18-64, Without Health Insurance, 1987-2000



Source: Employee Benefit Research Institute estimates from the March Current Population Survey, 1988-2001 Supplements.

Percentage of American Children Under Age 18 Without Health Insurance, 1987-2000

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Straight Talk America

McCain: Arizona Children Need Healthcare Funds

02/05/2003

U.S. Senator John McCain today introduced legislation to restore funding to the State Children's Health Insurance Program that provides health coverage for millions of uninsured children in the United States, 50,000 of which are in his home state of Arizona. His floor statement follows:

"Mr. President, I am pleased to join Senators Rockefeller, Chafee and a bipartisan group of my colleagues in introducing a bill to restore funding which was previously allocated to the State Children's Health Insurance Program (SCHIP).

"Established in 1997 as part of the Balanced Budget Act, SCHIP was developed as a means for states to provide basic health coverage for uninsured children of low income families, who are not eligible for coverage under Medicaid. Through the federal-state matching program, SCHIP has provided coverage for millions of uninsured children. In fiscal year (FY) 2001, 4.4 million children were enrolled in SCHIP. Today every state in the country, five territories, and the District of Columbia are using SCHIP to develop innovative programs to expand health coverage to even more children.

"In my home State of Arizona, our SCHIP program, KidsCare, was developed to provide low income children with medical, dental, and vision coverage. KidsCare has successfully enrolled almost 50,000 uninsured children and is anticipating reaching 60,000 by FY 2004. When Arizona found that children are more likely to receive health care if their parents also hav access, and the flexibility of SCHIP enabled Arizona to expand its program. Last October Arizona began covering not just childr n, but also th ir parents. Arizona now provides h alth

coverage to almost 8,000 uninsured parents. Although a substantial number of eligible children and parents still need coverage, I believe this relatively young program is nothing short of a success.

"Due to Congressional inaction, approximately $2.7 billion of unspent SCHIP funding reverted to the Treasury at the end of last year. The bill we are introducing today would return that money to SCHIP, ensuring that funds are allocated to the states that need more funding to continue existing programs, while allowing other states to develop new and innovative programs to help our nation s children get access to health care.

"The number of uninsured Americans reached 41 million in 2001 and continues to rise. However SCHIP is successfully reducing those numbers for one of the most vulnerable populations in our nation - our children. I hope the Senate will act expeditiously on this important legislation to return the funds that belong in SCHIP and to ensure that we are expanding, not reducing, the number of children covered through this innovative program."

THIRD WORLD TRAVELER

"Going Bare"

Uninsured Portion of US Population Is Growing Rapidly, Survey Discloses

Public Citizen Health Letter, February, 1999

Sidney M. Wolfe, Editor

Eight years ago, the federal government adopted a policy statement called HealthyPeople2000, which set a goal to "improve the financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving at a minimum, screening, counseling and immunization services"-in short, to guarantee that no one would be completely uninsured for health care when the new millennium began. This declaration was occasioned by a distressing if not scandalous situation: More than 35 million residents of the U.S. lacked access to rudimentary health care.

Seven years later, in September 1998, the Census Bureau estimated that "43.4 million people in the United States were without health insurance coverage during the entire calendar year of 1997 . . . up 1.7 million from the previous year," and there is no sign that since then the increase has stopped or even slowed. It is clear that "going bare"-the jargon for lacking access to health care-is becoming a way of life for more and more Americans, and that the Universal Declaration of Human Rights (to which the U.S. pays lip service) continues to be ignored in the richest nation in the world.

That declaration states that "everyone has a right to ... health and well being of his family, including ... medical care and the right to security in the event of ... sickness [or] disability." By the year 2000-less than a year from now-a situation that was bad a decade ago and bad now will be even worse.

---------- DOCUMENT HEADER ----------

---------- DOCUMENT HEADER ----------

ARIZONA STATE LEGISLATURE

Forty-fifth Legislature – First Regular Session

STATEWIDE HEALTH CARE INSURANCE PLAN TASKFORCE

Minutes of Meeting
Tuesday, December 11, 2001
House Hearing Room 4 -- 1:00 p.m.

(Tape 1, Side A)

Cochairman Cirillo called the meeting to order at 1:08 p.m. and the secretary noted attendance.

Members Present

Senator John Verkamp
Senator Virginia Yrun
Dr. George Burdick
Mr. Erin Collins
Senator Edward Cirillo, Cochairman
Representative Linda Binder
Representative Robert Cannell
Representative Tom O'Halleran
Mr. Terry Cooper
Representative Jim Carruthers, Cochairman

Speakers Present

Michelle Taylor-Brklacich, Consultant, William M. Mercer, Inc.
Steven P. Schramm, Principal, William M. Mercer, Inc.
Leigh Cheatham, Executive Director, Health Care Group
Dr. Howard J. Eng, Southwest Border Rural Health Research Center, University of Arizona
David Griffis, Griffis Consulting
Pete Wertheim, House Majority Analyst

Introduction

Cochairman Cirillo welcomed everyone present and advised that agenda item 4 will follow immediately after the first presentation. He also noted that no one is in attendance to make a presentation on behalf of Arizona State Retirement System (ASRS).

Presentation: Assessment of Arizona Health Care Coverage Follow-up

Dr. Howard J. Eng, Southwest Border Rural Health Research Center, University of Arizona, presented an Assessment of Arizona Health Care Coverage (see Attachment 5). The charts cover the following topics:

U.S. and Arizona uninsured population estimates: 1996-2000
Uninsured ranking for all ages: top 15 States (Arizona ranked 9th in 2000)

U.S. and Arizona uninsured under 65 population estimates: 1996-2000
Uninsured ranking for under age 65: top 15 States (Arizona ranked 10th in 2000)

U.S. and Arizona uninsured under 18 population estimates: 1996-2000
Uninsured ranking for under age 18: top 15 States (Arizona ranked 14th in 2000)

Arizona 0-17 age group breakdown 1999 survey (25.6% uninsured)
Arizona 18-24 age group breakdown 1999 survey (40.2% uninsured)
Arizona 25-34 age group breakdown 1999 survey (30.5% uninsured)
Arizona 35-44 age group breakdown 1999 survey (21.2% uninsured)
Arizona 45-64 age group breakdown 1999 survey (19.2% uninsured)
Arizona 65+ age group breakdown 1999 survey (0.4% uninsured)

Arizona Rural vs. Urban breakdown 1999 survey (23.9% urban/27.2% rural uninsured)
(44.4% employer based coverage urban/31.0% employer based coverage rural)

Dr. Eng responded to questions. He noted that the 65+ chart does not total 100 percent because it includes only single coverage over a one-year period.

Discussion of Recommendations

Cochairman Cirillo solicited comments on a draft proposed bill that would establish the Statewide Health Care System Task Force (Attachment 6). He pointed out that the name of the task force has been changed to eliminate the word "insurance," and that although the bill names three members from each legislative body, increasing that number to four would eliminate a problem created by the current Senate makeup of equal numbers from both parties.

David Griffis, Griffis Consulting, advised that the proposed legislation includes an additional task force member from the University of Arizona Health Science Center. He reviewed the proposed bill section by section, asking Members for comments, additions or objections as he did so.

Senator Cirillo pointed out that page 2, line 43 of the proposed bill would extend the life of this Committee.

Senator Cirillo and Mr. Griffis responded to questions.

Representative Carruthers commented that this is enabling legislation to allow the task force to move forward.

Mr. Collins proposed additional language to include smaller employers, particularly in rural areas of the State, such as the following:

> ". . . make recommendations regarding establishment of programs to encourage private employers with fewer than 100 employees to cooperatively purchase or fund medical benefit programs including, without limitation, partnership with the AHCCCS program."

He explained that his goal is to provide a vehicle to bring together larger numbers of insured lives who are actively working in order to spread the risk. Discussion ensued between
Mr. Collins, Senator Cirillo

health spending was heavily subsidized. Both groups had similar health outcomes even though those with high-deductible plans spent less on health care. This is particularly significant since the high-deductible plans in the RAND experiment gave even greater incentives to forgo care than do health accounts.

Myth: Health Accounts Don't Control Costs.

In South Africa, health account holders on average pay 11 percent less for nonchronic prescription drugs than those with traditional insurance, because health accounts encourage patients to shop and control costs. Such economizing explains why health account premiums in South Africa are growing at the same rate as income - and are declining relative to income when enrollees' savings are subtracted - while traditional health insurance premiums are rising at an increasingly faster rate than income.

Senate Minority Leader Tom Daschle (D-S.D.) and Sen. John Breaux (D-La.), sensed this when they introduced a health accounts bill in 1992: "We feel that, while the [health accounts] concept does not provide the total solution to the crisis in health care access, it does begin to address the critical aspects of increasing costs and utilization by consumers."

Myth: Health Accounts Help Only the Healthy & Wealthy.

This perennial criticism says health accounts attract desirable risks away from traditional insurance pools and increase premiums for those who remain. The criticism is rebutted by numerous studies.

A separate RAND study found that when given a choice of MSAs or managed care plans, the families that chose MSAs had lower incomes and greater health care needs than families that chose managed care. The Urban Institute has concluded, "on average, lower wage workers would benefit from switching to MSA/catastrophic plans." Finally, NCPA's study of the South Africa experience concluded that MSA holders were not healthier as a group.

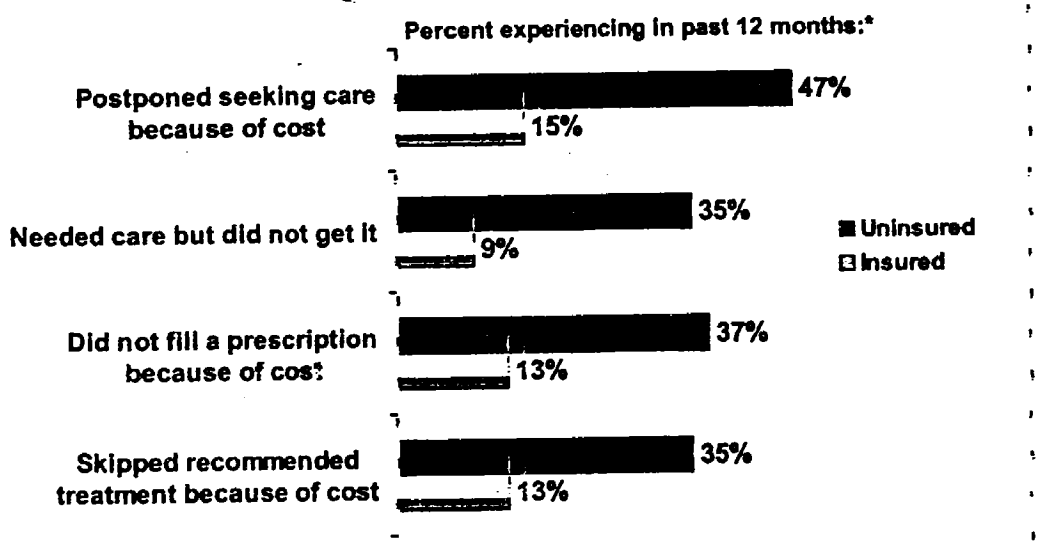
Moreover, this criticism has it backward. People are already abandoning insurance pools because third-party insurance has become too expensive.

The Census Bureau estimates that from 2000 to 2001, the number of uninsured Americans with annual household incomes above $75,000 grew by one million, making them the fastest growing uninsured population. The Center for Studying Health System Change reports one-fifth of uninsured workers are offered - but decline - employer coverage, and two-thirds say cost is the reason. Health accounts

The uninsured are more likely to postpone or forgo needed care. Almost half of the uninsured postponed seeking care in the past 12 months because of cost and over a third did not receive needed care or skipped a prescribed drug or treatment – gaps that are three to four times higher than for those with health insurance.

Chart 2

Barriers to Health Care by Insurance Status, 2003



Notes: *Experienced by the respondent or a member of their family. Insured includes those covered by public or private health insurance.

Source: *Kaiser 2003 Health Insurance Survey.*

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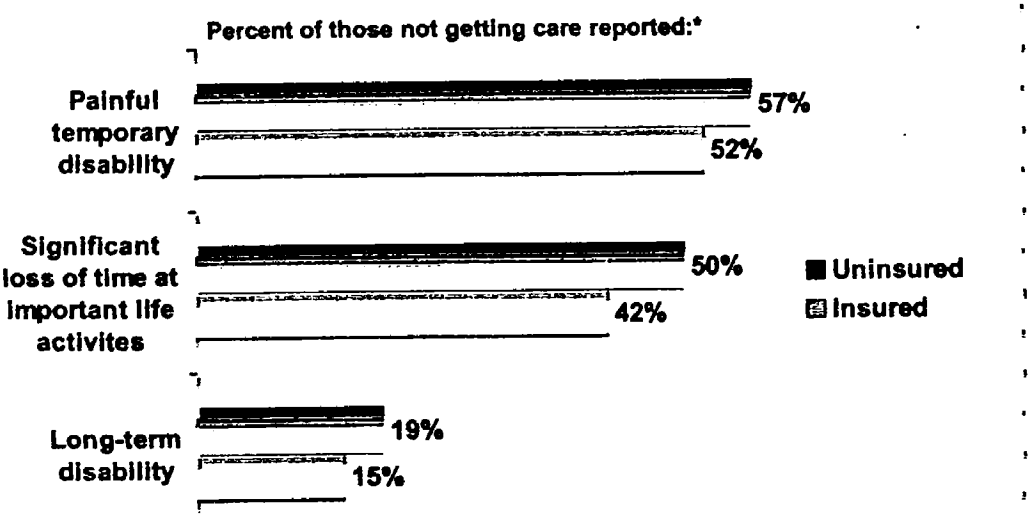
There are often serious consequences for both uninsured and insured adults who forgo needed care.
Half report that they are temporarily disabled by their health problem, and 15-20 percent actually suffer long-term disability.

Chart 3

Consequences of Not Getting Care by Insurance Status, 2003



Notes: *Experienced by respondent or a member of their family.
No significant differences between groups for any of these measures.
Insured includes those covered by public or private health insurance.

Source: *Kaiser 2003 Health Insurance Survey.*

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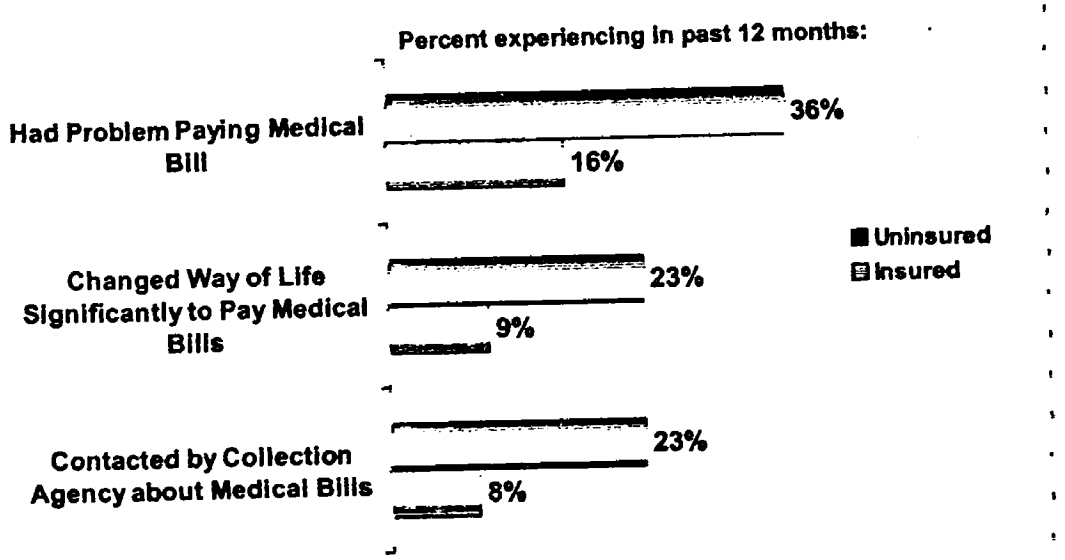
Medical bills are a greater burden for the uninsured.
Over a third of the uninsured had problems paying medical bills in the past year. The unpaid bills were substantial enough that many of the uninsured had been turned over to collection agencies – and nearly a quarter of uninsured adults said they had changed their way of life significantly to pay medical bills.

Chart 4

Financial Burden of Medical Bills by Insurance Status, 2003



Note: Insured includes those with public or private insurance coverage.
Source: *Kaiser 2003 Health Insurance Survey.*

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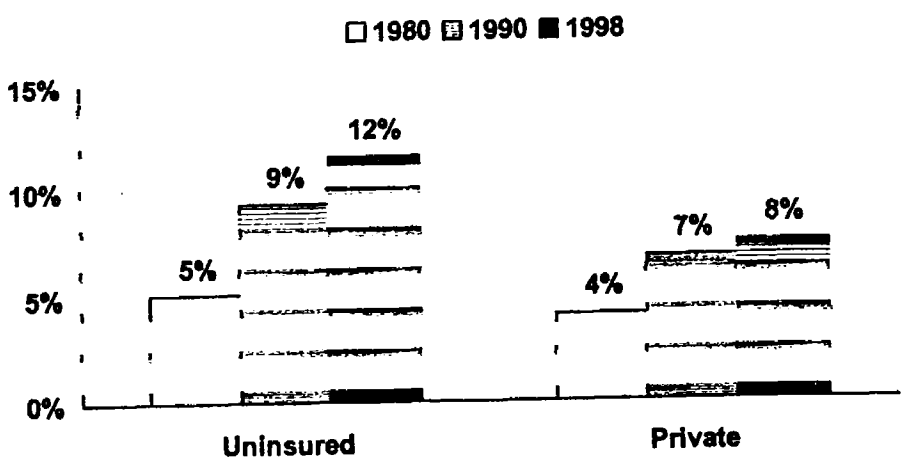
THE IMPACT OF INSURANCE ON PERSONAL HEALTH

SUMMARIZED FROM "SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED"

Incr asingly, the uninsured are more likely to be hospitalized for an "avoidable condition" – problems that could have been prevented had a person received appropriate and timely outpatient care.
In 1998, 12 percent of the uninsured compared to 8 percent of the privately insured were hospitalized due to a preventable health problem.

Chart 5

Hospitalization Rates for Avoidable Conditions, by Health Insurance Status, 1980-98



SOURCE: Kozak, LJ, 2001 from Hadley, J., *Sicker and Poorer: The Consequences of Being Uninsured*, 2003, prepared for KCMU.

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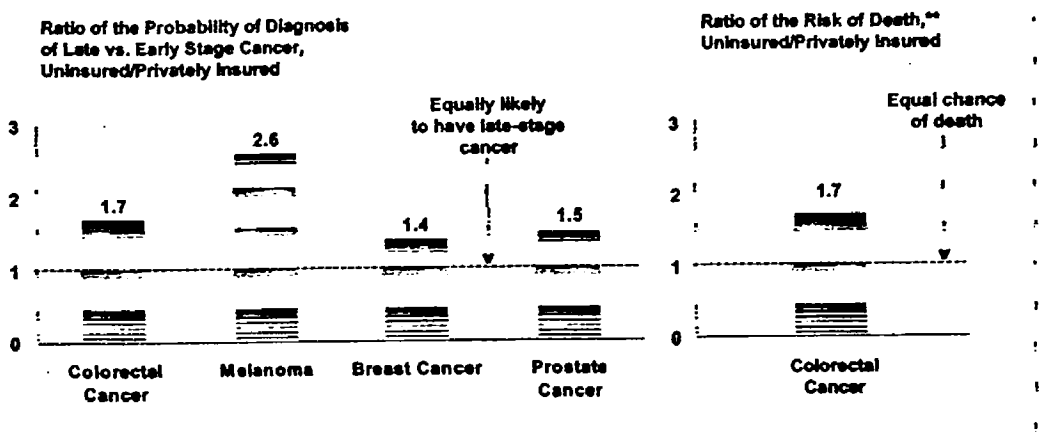
The uninsured are more likely to be diagnosed in the late stages of cancer. The uninsured are up to two and a half times more likely to be diagnosed in the late stages of cancer than those with health insurance. The uninsured are also more likely to die from cancer, as in this example of colorectal cancer where the uninsured are 70 percent more likely to die from it than the privately insured.

Chart 6

Diagnosis of Late-Stage Cancer,
Uninsured vs. Privately Insured,* 1994



* Privately insured all had commercial indemnity plans.
** Among cancer cases identified in 1994; mortality follow-up through 1997.
All differences are statistically significant after adjusting for age, sex, race/ethnicity, comorbidity, marital status (when appropriate), smoking status, socioeconomic status, education, stage at diagnosis, and treatment
SOURCE: Roetzheim RG, et. al., 1999, 2000 from Hadley, J., *Sicker and Poorer: The Consequences of Being Uninsured*, 2003, prepared for KCMU.

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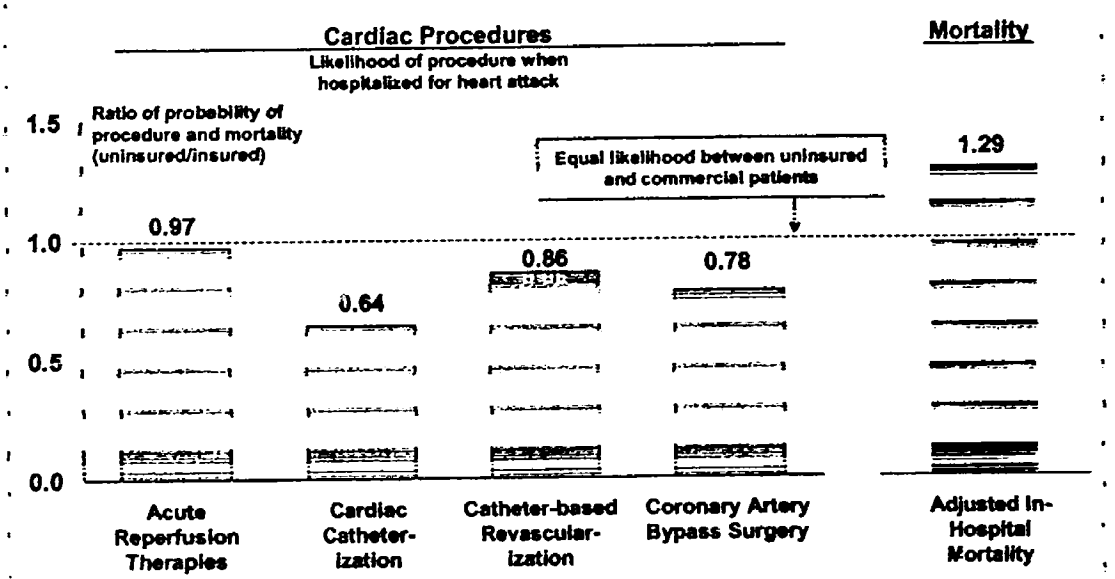
Uninsured adults who have been hospitalized for heart attacks are over 25 percent more likely to die while in the hospital than privately insured adults. While the uninsured are just as likely to receive therapy to improve blood flow to their hearts in the acute stages of their heart attacks, they are less likely to undergo further costly diagnostic and therapeutic interventions.

Chart 7

Differences in Access to Cardiac Procedures and In-Hospital Mortality among Patients with Acute Heart Attacks,

Uninsured vs. Commercial (FFS) Insurance, 1994-1996



Note: Both sets of data were adjusted for social and demographic factors, as well as clinical symptoms and comorbidities common among cardiac patients.
All differences are statistically significant except for acute reperfusion therapies
SOURCE: Canto, 2000 from Hadley, J., Sicker and Pooler: The Consequences of Being Uninsured, 2003, prepared for KCMU.

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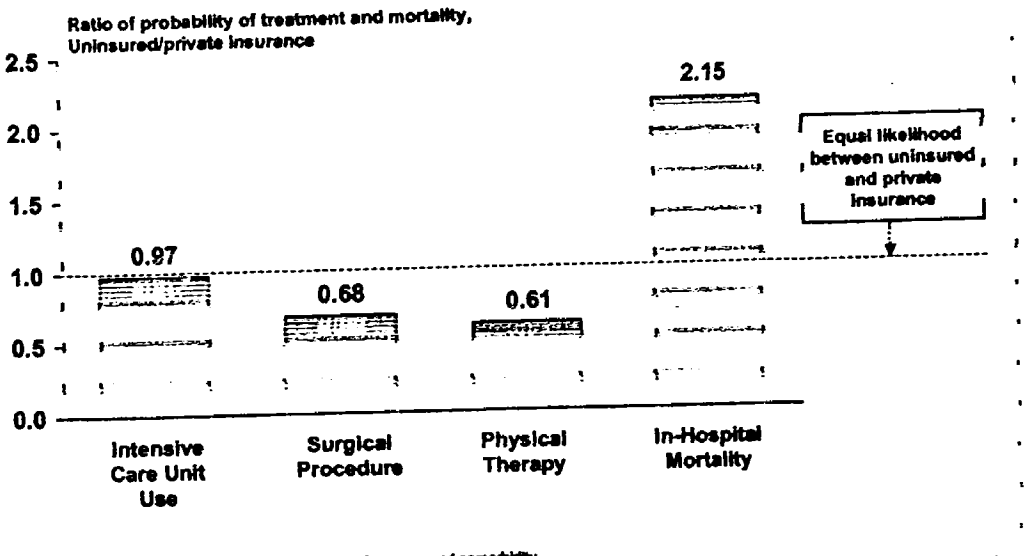
Among those hospitalized for a traumatic injury, those without insurance are more than twice as likely to die while in the hospital – even after controlling for differences in the severity of the injury.
The uninsured are just as likely to be cared for in intensive care units, but are less likely to undergo a surgical procedure or receive physical therapy for their injuries.

Chart 8

Differences in Trauma-Related Care and Mortality, Among Hospitalized Uninsured vs. Privately Insured, (Ages 15-64), 1990



Note: Odds ratios were adjusted for age, sex, race, injury severity score, and comorbidity. All differences are statistically significant except for intensive care unit use
SOURCE: Haas and Goldman, 1994 from Hadley, J., *Sicker and Poorer: The Consequences of Being Uninsured*, 2003, prepared for KCMU.

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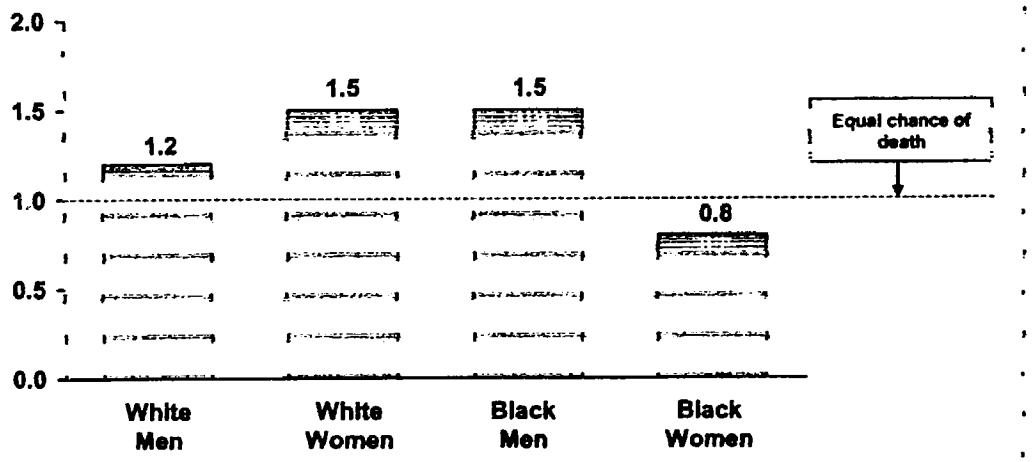
Being uninsured carries a higher risk of premature death for many.
With the exception of black women, this research found that uninsured nonelderly adults are 20 percent to 50 percent more likely to die over a five-year period of study than those with job-based health coverage.

Chart 10

Relative Risk of Death

Uninsured vs. Employer-Based Coverage Among 25-64 Year Olds over a Five Year Period, 1982-87



Note: All differences are statistically significant after adjusting for age and income except for black women.
SOURCE: Sorlie, PD, 1994 from Hadley, J., *Sicker and Poorer: The Consequences of Being Uninsured*, 2003, prepared for KCMU.

KAISER COMMISSION ON Medicaid and the Uninsured

SUMMARY

Health insurance makes a difference in how people access the health care system, and delaying or not receiving treatment can lead to more serious illness and avoidable health problems, which ultimately makes a difference in people's health. Leaving a substantial share of our population without health insurance affects not only those who are uninsured, but also the health and well-being of our nation.

SOURCES

The *Kaiser 2003 Health Insurance Survey* reports findings from a nationally representative random sample of 2,507 respondents ages 18 to 64 years, including 2,042 insured respondents and 457 uninsured respondents. Researchers at the Henry J. Kaiser Foundation designed and analyzed the survey. Fieldwork was conducted by telephone between April 30 and July 20, 2003 by Princeton Survey Research Associates. The margin of sampling error is ±2 percentage points for the total sample; for insured respondents it is ±2 percentage points; and for uninsured respondents it is ±5 percentage points. For results based on smaller subsets of respondents, the margin of error is higher. Note that sampling error is only one of many potential sources of error in this or any other public opinion poll.

Sicker or Poorer: The Consequences of Being Uninsured, authored by Jack Hadley, Ph.D., of the Urban Institute, synthesizes the major findings of the past 25 years of health services research, assessing the most important effects of health insurance. The report evaluates thousands of citations and 230 research articles to examine the consequences of being uninsured. The executive summary, the full report and briefing charts are available at http://www.kff.org/content/2002/20020510/.

http://www.deseretnews.com/dn/view/1,1249,100003040,00.html?

Saturday, May 22, 1999

Arizona doctors lament health-care plague: worst uninsured rate in U.S.

The Arizona Republic

PRESCOTT, Ariz. - The portion of Arizonans who don't have medical insurance has grown to 28 percent, ranking Arizona worst in the nation for uninsured. And some participants at 74th Arizona Town Hall on future health care say they hope the statistic will spark political attention to the problem. "We thought it was bad when 15 (percent) to 17 percent of Arizonans were uninsured," said Dr. Scott Gorman of Phoenix, interim executive director of Mayo Health Plan Arizona. "We can only hope it is now finally on the radar screen."

Participants learned that uninsured Arizonans don't have access to preventive medicine. They wait until their condition is acute, then go to a hospital emergency room for treatment. In most Arizona towns and cities, the emergency rooms are seriously overcrowded. **And an increasing flow of illegal immigration is also adding to the ranks of the uninsured.** "We are seeing a real influx of undocumented people into the state now," said Lee Knaeble, a business owner who is on the Sierra Vista Community Hospital Board. "This could mean more people showing up at emergency rooms because that is the only way they can access health care."

But the real problem isn't immigration, said many at the Town Hall. It's unaffordable health care. Andy Groseta, a third-generation cattle rancher and chairman of the board of Northern Arizona Health Care, said most of the workers in managerial positions at large ranches and farms had insurance 10 to 15 years ago. Now, fewer than 50 percent do.

Even fewer ranch and farm hands have it, and their work is more dangerous. "Arizona has one of the lowest unemployment rates in the U.S.," he said. "How can we have one of the highest rates of uninsured?" The growth of low-paying service-sector jobs is seen as the basic factor driving the health insurance crisis. Also, the rise of contract work is pushing many people who work full time out of insurance plans.

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The Great Wal-Mart Wars

Ruth Rosen, San Francisco Chronicle
June 30, 2003

Viewed on October 8, 2003

Would you like a Wal-Mart "supercenter" store to move into your community? Think of the low prices and the convenience of one-stop shopping! You just park once and get whatever you need -- groceries, drugs, plants, toys, dog food, even eyeglasses.

Sounds great, doesn't it? So why have nearly 200 communities refused to allow such big-box stores to enter their lives? Do they know something we don't?

To find out, I embedded myself in the Wal-Mart wars that have recently broken out in Contra Costa County. What I learned, in a nutshell, is that Wal-Mart's nonunion, big-box stores drag down other workers' salaries, destroy downtown businesses, prevent smart-growth development and increase traffic congestion. What really surprised me though is that we, the taxpayers, end up subsidizing Wal-Mart stores by paying for the health and retirement needs of its workers.

Wal-Mart has announced its intention to open 40 new supercenter stores -- each the size of four football fields -- in such fast-growing California suburban areas as Contra Costa County.

But Contra Costa County has fought back. A year ago, Martinez prevented a traditional Wal-Mart store from expanding into a supercenter that could sell groceries. On June 3, the county Board of Supervisors voted to ban such supercenter stores from unincorporated areas of the county.

In making its decision, the board cited a study done by the San Diego County Taxpayers Association (SDCTA), a nonprofit, nonpartisan organization. It found that an influx of big-box stores into San Diego would result in an annual decline in wages and benefits between $105 million and $221 million, and an increase of $9 million in public health costs. SDCTA also estimated that the region would lose pensions and retirement benefits valued between $89 million and $170 million per year and that even increased sales and property tax revenues would not cover the extra costs of necessary public services. "Good jobs, good pay, and good benefits should be the goal of an economy," SDCTA concluded, "and supercenters are not consistent with that objective."

Wal-Mart, as is its custom, has launched a counterattack against Contra Costa's ordinance. The company parachuted in platoons of signature-gatherers who are stationed outside discount stores and asking shoppers to sign a petition that would place the board's decision on a ballot. If they collect 27, 000 legitimate signatures, Wal-Mart could reverse the board's ban.

In response, a coalition of community groups have mobilized to defeat Wal- Mart's counterattack. But they face a formidable enemy. Over the last 40 years, Wal-Mart has grown into the nation's biggest employer and the world's largest retailer. Every two days, Wal-Mart opens another superstore. It has more people in uniform than the U.S. Army. Last year, it banked about $7 billion in profits.

The troops fighting Wal-Mart's invasion of Contra Costa County include the Gray Panthers, small businesses, dozens of churches, the National Organization for Women, and environmental and smart-growth activists. Young people, recruited by the Association of Community Organizations for Reform Now (ACORN), fan out daily to discount stores and try to convince shoppers not to sign Wal-Mart's petition. They even carry cards that allow voters to withdraw their signature if they have already signed the petition.

The generals in charge of this community resistance are union leaders. John Dalrymple, director of the Contra Costa Central Labor Council, admits they face an uphill battle. The giant retailer is infamous for its take-no-prisoners, anti-union policies. Wal-Mart's ability to offer such low prices, as any union member will tell you, has been achieved by paying its workers -- or "sales associates" -- low wages, offering unaffordable health coverage and no retirement benefits and importing most of its products from developing countries, some of which use child and prison labor.

The United Food and Commercial Workers (UFCW) Local 1179, located in Martinez, is headquarters for the war against Wal-Mart. Barbara Carpenter, the union's president, comes from a family whose members have worked for decades at retail companies that provided decent wages, affordable health benefits and pension plans. "It's about saving the American dream," she told me.

Wal-Mart, she points out, lowers wages among working families and crushes family businesses. "It not only pays workers less than most of its retail competitors, two-thirds of workers don't have health-care coverage -- a cost taxpayers are picking up across the country."

Did she say taxpayers? That's right. We, the customers, get such low prices and convenient shopping because we, the taxpayers, subsidize Wal-Mart profits by paying for county public health services, food stamps, and social services for its retired employees.

So should you shop at Wal-Mart? To make up your mind, consider this: If you earn a livable wage or are protected by a union, you can probably buy all your monthly needs at Wal-Mart. But that's because the average Wal-Mart employee, who earns about $15,000 a year, cannot do the same.

Convenience and cheap prices, it turns out, come with hidden costs.

Ruth Rosen is a columnist for the San Francisco Chronicle. She can be emailed at rrosen@sfchronicle.com

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Wal-Mart makes American taxpayers pay for store employee health benefits

Wal-Mart is doing more than slashing prices these days; it's ripping into the fabric of the U.S. health care safety net by shifting the billion dollar burden of its employee's health care coverage to taxpayers. Here's how.

www.walmartyrs.com
National Wal-Mart Day of Action
Oregonians for Health Security

Because of strict eligibility requirements, huge copayments, and big deductibles, only about 38 percent of Wal-Mart's employees receive health benefits. In contrast, more than 60 percent of U.S. workers are covered by their company's health benefit plan. Wal-Mart employees who do have coverage must pay about half the insurance premium cost. In contrast, other workers pay about 28 percent.

38% rec. health care benefit

Is that enough

As a result of this irresponsible corporate health care policy, more than 450,000 Wal-Mart employees — mostly women — have no health insurance. And that places the burden on state programs to provide needed care to Wal-Mart employees' families.

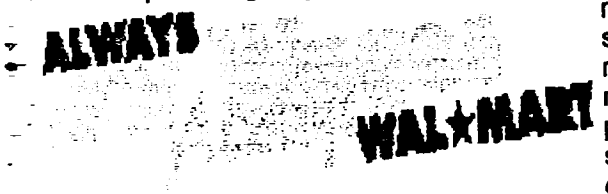
In Georgia, for instance, a study showed that 10,455 children in the state's taxpayer-financed PeaceCare program were dependents of Wal-Mart employees. In contrast, the conbined total of dependents of Target, K-Mart, J.C. Penney, and Sears employees in the program was less than 10 percent of Wal-Mart's total.

ortends a gloomy future rather than the new age of
oduction that was Henry Ford's vision.

fact Wal-Mart is the perfect example of what is wrong with the new low-wage economy and s effects on our society.

t's start with wages. Henry Ford wanted automobile workers to be able to buy the cars his ompany produced. Although profoundly anti-union, he made it a point to pay wages that re above the prevailing wage of the time.

Val-Mart does precisely the opposite. Its wage and benefit programs are designed to keep osts down and, in the process, because of its economic influence and market share, it ves down prevailing wage rates in the communities in which it operates. Wal-Mart has recently demanded cost data from suppliers so it can show them how to reduce costs. For many of them, this means lowering labor costs to reduce prices of goods sold on Wal-Mart shelves. Wal-Mart's purchasing power even drives down manufacturing wages



the developing world.

'al-Mart's strategy is to use part time workers to reduce its benefit costs. "Associates" - as e company workers are dubbed - are told that if they work 34 (recently increased from 28) ours a week then they are "full time workers". According to Forbes, the self-styled capitalist too!, employees at Wal-Mart currently earn an average hourly wage of $7.50-20% to 30% ss than unionized workers at Target and Kmart. The typical Wal-Mart employee earns 8,000 and isn't eligible for or cannot afford health benefits.

Val-Mart has employed large numbers of women associates that it has paid less than their ale counterparts. By maintaining these discriminatory practices Wal-Mart has reinforced its ow wage structure and improved its bottom line. In 2001 a class-action lawsuit was filed challenging Wal-Mart's gender discrimination. Up to 1.5 million women workers could win amages.

Unlike Henry Ford, Wal-Mart seems unconcerned that its own employees are unable to fford the products that it sells. A recent analysis shows that a family of three with a single-arent breadwinner making a representative wage at the local Wal-Mart could not provide asic necessities for that family based on an "adequate but austere" standardized budget for central Kansas - ev n with the employee discount!

Val-Mart uses a predatory business model based on securing a competitive advantage from the low wages it pays employees and from its larger inventory. Typically, Mom-and-Pop local businesses are forced from local markets first, soon followed by less efficient larger ompetitors. Once the competitors are driven out, Wal-Mart slowly raises prices over a twelve to eighteen month period so consumers won't really notice.

pposition to Wal-Mart is often based on its anti-competitive business practices. Communities in which there is opposition to Wal-Mart or other large-scale retailers sometimes try to nact special zoning ordinances limiting the size of stores. These tactics an be effective, especially if the community is well organized. Increasingly, however, Wal-Mart's superior financial resources are the key factor. They outspent a highly organized citizens group in Portage, MI, by 10-1 on a referendum. Wal-Mart routinely overwhelms citizens groups or simply moves to the next town and gets a higher bid to have the store built here instead. Wal-Mart is most concerned with preventing the unionization of its employees precisely because that is what offers the most far-reaching challenge to its corporate practices.

Democratic Socialists of America believes that it is imperative to force Wal-Mart to change. We are working along with many others to challenge the low-wage economy that increasingly dominates the lives of most working people. Ultimately the American economy cannot be sustained when driven mainly by the purchasing power of a relatively small group of well-off consumers. Only an economy in which the vast majority of workers earn enough to do more than just get by can bring prosperity to all Americans. It is impossible to envision that kind of economy as long as Wal-Mart is able to engage in business-as-usual.

We have no illusions that we can remake the economy without Wal-Mart. Instead we, and the broad progressive community, must change the basic political and economic conditions that allow Wal-Mart to ignore the well-being of its workers and the communities in which it operates.

The key to real change is to drive up the wages of Wal-Mart workers. Unionizing Wal-Mart workers will lead to higher wages and better benefits for all employees, will drive up wages in local communities, and will change the culture of the institution.

The United Food and Commercial Workers union is engaged in a major campaign to Wal-Mart workers. We fully support that campaign and we support legislative efforts to level the playing field. Labor law reform requiring employers to recognize a union as soon as a majority of workers have signed cards and preventing employers from dragging out bargaining is necessary to enable workers to better secure their rights.

Government can also act to raise and enforce minimum wage legislation. Living wage legislation that forces employers to provide prevailing local wages that include the cost of health care can also be enacted. Living wage legislation in many communities is limited to the employers providing municipal services, but we believe such legislation can be expanded to cover the employees of companies like Wal-Mart that benefit from tax breaks provided in many economic development packages.

Employers have always resisted unionization. But in fact our economy has always provided more for most Americans when large portions of the work force were unionized and could buy what their neighbors produced. This is one of the reasons why the loss of so many union jobs in the manufacturing sector is distressing. All of us must work to change the labor laws, support unions and their campaigns, and get the government on our side in order to abolish th low wage economy. Wal-Mart is a good place, but by no means the only place, to start.

Our factual references are from information provided in company filings and news articles as reported by **United for a Fair Economy as well as **Reuters, Forbes, Fortune** and the **World Bank**. Wal-Mart workers interested in learning more about the UFCW should contact the union or visit its websites: www.walmartswaronworkers.com and www.ufcw.org.*

Flagstaff Activist Network

WAL-MART MYTHS AND REALITY

WAL-MART OR WORLDMART CASE STUDY

DOES FLAGSTAFF REALLY NEED A SUPERSTORE?

Myth: **Wal-Mart creates "hundreds" of new jobs for communities.**
Fact: Studies show that for every two jobs created by a Wal-Mart store, the community loses three. Jobs that are retained by a community are merely shifted from local businesses to the giant retailer. In a 1994 report, the Congressional Research Service warned Congress that communities need to evaluate the significance of any job gains at big-box stores against any loss of jobs due to reduced business at competing retailers. The report also pointed out that these so-called new jobs "provide significantly lower wages then jobs in many industries, and are often only part-time positions, seasonal opportunities, or subject to extensive turnover." The **Real Story** is that when Wal-Mart moves into the neighborhood, it devours local businesses and lowers community living standards.

Myth: **Wal-Mart has "always low prices, always."**
Fact: The local newspaper in Carroll County, Arkansas conducted a **test of Wal-Mart's low price claim**. Surveying a list of 19 common household items at six Wal-Mart stores over a one month period, the newspaper staff found that **Wal-Mart was cheapest on only two of the items** . The lowest register receipt for all 19 items was $12.91. The highest total for all items came from Wal-Mart at $15.86. The **Real Story** is the high cost of Wal-Mart's prices: lower wages, more imports, lost U.S. jobs, lower community living standards.

Myth: **Wal-Mart's presence in a community generates tax revenues.**
Fact: Studies conducted by small towns on the impact of proposed Wal-Mart stores have shown that tax revenue reductions are more likely to occur after a Wal-Mart moves into an area.

A Maryland study showed that in the years following the arrival of Wal-Mart, "town tax receipts from personal property and ordinary business corporation taxes grew but at a declining rate." The study said that "the expected growth in income taxes may have been offset by low-wage jobs offered by the large retailer and by the loss of employment in competing businesses. . . ."

Myth: **Wal-Mart's workers receive good health benefits.**
Fact: Wal-Mart's Health Coverage Leaves Most Workers Uncovered.

Huge employee premium payments and big deductibles keep participation in Wal-Mart's health plan to 38% of mployees. That's 6 out of every 10 employees–more than 425,000 Wal-Mart employees,

most of them women, who have no company provided health coverage. Nationally, more than 60% of workers are covered by company paid health plans. There's more: Wal-Mart workers pay insurance premiums that cover close to half of Wal-Mart's health plan expenses. The national average shows that employee premiums cover just over 25% of health plan expenses incurred by companies nationwide. The **Real Story** is that Wal-Mart freely acknowledges shifting its health care costs to taxpayers and responsible employers. A company spokesperson said, "[Wal-Mart employees] who choose not to participate in [Wal-Mart's health plan] usually get their health-care benefits from a spouse or the state or federal government." Wal-Mart is the biggest beneficiary of its health plan because the company shifts $1 billion in health care costs to the government and responsible employers.

Myth: **Wal-Mart "Buys American" and Wal-Mart "Brings it Home to the USA."**

Fact: Two 1998 studies that surveyed clothing on Wal-Mart store racks and shelves found 80% and sometimes more thatn 9o% of the apparel items were produced overseas, many in countries where sweatshops and child labor are prevelant.

"The truth is," says the National Labor Committee, "Wal-Mart has moved far more production offshore than the industry average." There's more: Commenting on Wal-Mart's "Buy Mexican" program, an expert on economic nationalism said Wal-Mart is ". . .shamelessly manipulating nationalist sentiments in both countries. . . . For all its public nationalism, Wal-mart is reinvesting its all-American dollars overseas."

Confronting Wal-Mart: How and Why

The battle against Wal-Mart is about maintaining quality community living standards. The legacy of Wal-Mart isn't lower prices. The true legacy of Wal-Mart is lower living standards for hard working Americans and those overseas.

The fact is for every Wal-Mart store that opens, jobs are lost to the community, the tax base shrinks, the number of workers with health benefits declines, and the number of workers eligible for welfare increases.

We have to confront Wal-Mart to stop the retail giant from turning good jobs into bad jobs, from turning taxpaying workers and their families into welfare-eligible families supported by taxpayers, and from turning workers with health insurance into the ranks of the uninsured.

Here's what each of us can do:

1. Be a good neighbor. Promise to shop at grocery stores that pay a living wage and provide affordable family health benefits.
2. Ask friends and family not to shop for groceries at Wal-Mart.
3. Be an active member of your community. Get involved in planning and zoning board hearings. Let the decision-makers know that you don't want Wal-Mart in your neighborhood.
4. Reach out to Wal-Mart workers. Give them the support they need to fight for their families and their future.

Let's stand up for ourselves and our families, and for our neighborhoods.

Let's say no to Wal-Mart!

Agendas can be obta /ia the Internet at http://www.azleg.state.az.us/iagenda/iagenda.htm

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ZONA STATE LEGISLATURE

Interim Meeting Notice

Open to the Public

Statewide Health Care System Task Force

Minutes 11-20-03 (Jeno W)

DATE: **Thursday, November 6, 2003**

TIME: **9 a.m.**

PLACE: **Senate Hearing Room 1**

AGENDA

1. Call to Order
2. Update on Health Care Programs
   Arizona Health Care Cost Containment System - Anthony Rodgers
3. Update on Self-Insurance
   Department of Administration - Betsey Bayless
4. Rebuttal on Self-Insurance
   CIGNA HealthCare - Jeff Terrill
5. Presentation on Long-Term Care Partnership - Stan Hovey
6. Adjourn

MEMBERS:

Senator Linda Binder, Cochair
Senator Carolyn Allen
Senator Robert Cannell
Senator Dean Martin
Kirk D. Adams
Terry Cooper
Nancy Koff

Representative Jim Carruthers, Cochair
Representative Amanda Aguirre
Representative Ted Carpenter
Representative Deb Gullett
Dr. George Burdick
Sandy Gibson

JK/tam
11/4/2003

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ARIZONA STATE LEGISLATURE

STATEWIDE HEALTH CARE SYSTEM TASK FORCE

Minutes of the Meeting
Thursday, November 6, 2003
9 a.m., Senate Hearing Room 1

Members Present:
Senator Linda Binder, Cochair
Senator Carolyn Allen
Senator Robert Cannell
Senator Dean Martin
Kirk D. Adams
Sandy Gibson
Representative Jim Carruthers, Cochair
Representative Amanda Aguirre
Representative Ted Carpenter
Representative Deb Gullett
Terry Cooper

Members Absent:
Dr. George Burdick
Nancy Koff

Staff:
Julie Keane, Senate Health Committee Analyst
Pete Wertheim, House of Representatives Health Committee Analyst

Senator Binder called the meeting to order at 9:06 a.m. and attendance was noted.

Anthony Rogers, Director, Arizona Health Care Cost Containment System (AHCCCS), provided an overview (Attachment 1) and update of the agency, noting the cost trends in health benefits with the key cost drivers being prescription drugs, hospital and physician services, acceleration of new technology, and aging population. He pointed out that as premiums have increased, coverage has been reduced or more of the cost has been passed on to the employees. Employment is affected as well, with many of the large corporations going out of state or out of country to obtain lower paid employees. He suggested that when people are unemployed, the risk shifts to the State.

Mr. Rogers explained that AHCCCS is one of Arizona's largest health care insurers, with funding received from federal, state, and county governments, as well as private dollars. AHCCCS acute care and KidsCare programs make up a statewide, managed care system which delivers acute care services through 11 prepaid, capitated health plans with several contractors in each region of the State. As of October 1, 2003, AHCCCS has an enrollment of 993,265 members. He briefly discussed the eligibility income levels and annual income standards of the enrollees. By 2005, he anticipates that 20% of Arizona's population will be covered by one of the AHCCCS programs. The challenge for the administration is to manage the membership level and yet reduce the liability to the state general fund.

In response to Representative Carruthers regarding enrollment projections beyond 2005, Mr. Rogers replied that much will depend on the economy and job creation. He noted that the maximum number of people using AHCCCS programs would be estimated at 22% of the population.

In response to Senator Allen, Mr. Rogers agreed that some businesses are providing employees with AHCCCS forms, specifically hourly employees.

Ms. Gibson mentioned that there was a report released last year that reviewed AHCCCS in-patient hospital reimbursement which indicated that AHCCCS was paying 12% below a hospital's actual costs. She wondered if there is any consideration to bring the in-patient pricing up to cover more of the costs rather than shifting the costs to other health carriers. Mr. Rogers acknowledged that cost shifting has occurred in the past and is something that does not help in keeping premium costs down. He suggested that AHCCCS is reviewing their reimbursement process to determine how to make it more equitable. He pointed out that one of their goals is to ensure an adequate primary care network to reduce the use of emergency rooms for primary care. Also, it is important to be more effective in deploying best practices in disease and chronic illness management.

In response to Representative Aguirre's questions, Mr. Rogers replied that he recognizes that the rural hospitals with less than 75 beds are at risk, because their fixed costs are much higher than the urban hospitals. He said that he is working with the Arizona Hospital Association (AHA) to find a solution. Also, AHCCCS is working on areas where disease management has been effective, such as asthma and diabetes. He added that AHCCCS is developing a program for overweight children to manage them to healthy weights.

In response to Mr. Adams questions, Mr. Rogers indicated that the dramatic increase in enrollment in AHCCCS is attributed to Proposition 204's raising the federal poverty level (FPL) to qualify for AHCCCS, as well as the fact that Arizona's economy is a small business one. He indicated that some states have as high as 25% of their population in similar programs as AHCCCS.

Mr. Rogers continued with his presentation, explaining that 71% of the AHCCCS budget comes from federal funds, 18% from the state general fund, and 11% for other funds. He added that the administrative costs are only 2.8% of total costs. He discussed the Proposition 204 budget growth, capitation trends, and cap rate drivers. He noted that there are many success stories for AHCCCS.

Mr. Rogers summarized his discussion with the strategic direction and focus for AHCCCS, which is to: 1) maximize federal dollars for health care coverage; 2) control escalating premiums and medical care costs; 3) reduce the number of uninsured; 4) drive improvement in quality of care; 5) provide information to employers about a health workforce; and 6) assure stability of the safety net. He talked about the Centers

of Excellence, patient care planners, treatment options, and targeted medical management. He concluded with the fact that although there is lots of work to do, he feels that AHCCCS is well positioned to address the issues.

In response to Representative Gullett, Mr. Rogers replied that the report that focuses on national acute care programs indicated that Arizona's program was better than any other state. There is a need to continue to explore an optimal solution for reducing costs, while at the same time integrating a pharmacy benefit. He noted that many states are doing some innovative programs with pharmacy benefits, which AHCCCS is reviewing. Other programs to address include the uninsured and senior populations.

In response to Senator Binder, Mr. Rogers explained that many seniors have taken advantage of the new prescription program established by an executive order from the Governor. He noted that they would like all seniors to have access to the program; however, part of the problem is getting the word out to the qualified individuals. He suggested that one of the methods of notifying everyone would be to mail a card to all seniors who qualify in the State.

Steve Barclay, Lobbyist, CIGNA Healthcare of Arizona, introduced **Jeff Terrill, Chief Executive Officer, CIGNA,** who provided background information and discussion points on the State employee health insurance program (Attachment 2). He emphasized that CIGNA is proud of their 30-year relationship with the State.

Mr. Terrill noted that subsequent to the passage of HB 2600 in 2000, the State declared that the contracted health plans serving State employees were no longer bound to the annual contractual rate caps. Each health plan was asked to provide the financial impact to rates as a result of the legislation. The range was between 9% and 70% and CIGNA was the lowest at 9%. CIGNA was awarded a contract of up to seven years (renewable by the State annually) effective October 1, 2001 based upon factors identified by the Arizona Department of Administration (ADOA). Since that award, CIGNA has gone through two annual rate adjustments, 14.97% effective October 2002 and 13.2% effective October 2003 which equates to $96.6 million. These increases were less than the medical inflation rates projected for the covered population.

Mr. Terrill suggested that it is fiscally prudent to weigh the risks and benefits of self-insurance compared to the arrangements the State currently has with CIGNA. The principal benefits of self-insurance include: 1) cash flow gain; 2) State premium tax savings; and 3) State benefit mandate exemption. The principal risks would include: 1) significantly greater financial exposure (claims, reserve adequacy, administrative expense); 2) less predictability of expense and harder to budget; and 3) fiduciary role and responsibilities. He pointed out that 41% of the states that self-insure offer only one plan option. In 2002, 17 states increased deductibles, 24 states increased physician copays, and 29 states increased pharmacy copays. In 2003, the majority of states indicated that they were likely to increase copays. During these same time periods, Arizona's plans have remained unchanged since October 2001. He noted that

the projection for self-funding costs in 2005 is $475 million and the CIGNA projection is the same.

Mr. Terrill commented that there are 25,000 employees and dependents currently in the CIGNA program who will need to find another doctor, and will lose optimal utilization and treatment compliance, as well as access to after hours and urgent care. Losing the CIGNA physician network could add in excess of $8 million to the self-insured arrangement. Additionally, the CIGNA fully insured arrangement could be reduced by 2% with a premium tax exemption.

Mr. Terrill expressed CIGNA's desire to continue to serve the State as they have for the past 30 years. He added that if the Request for Proposal (RFP) was structured to permit integrated bids, CIGNA and the bulk of their competitors would quote and the State would have more selections and competition.

Senator Allen indicated that she would like to have a list of all the entities that did not bid, as well as a list of the bidders. She also would like to know the reason why each company did not bid on the RFP.

Ms. Gibson noted that Blue Cross/Blue Shield (BC/BS) did bid; however, they found the nonintegrated feature of the bid to be challenging and submitted an integrated bid. She pointed out that most carriers would welcome the opportunity to identify some of the challenges in the structure of the bid.

In response to Senator Allen, Mr. Terrill explained that as a carrier, they are the pharmacy benefit management company, claims administrator, provider network, medical management company, as well as the disability manager. The RFP specified that a carrier could be awarded only one of the five functions in one of the regions in Arizona. The major carriers are not going to allow other carriers to manage part of the functions. He suggested that if the carriers could quote on an integrated basis, many would do so. He added that self-insurance is not a panacea where the State will save money. Instead, the State should review the features of the program as well as the risks. He brought up that under CIGNA, Arizona has a plan that is similar to self-insurance, which is the Preferred Provider Organization (PPO) plan.

Representative Carpenter questioned why the RFP was designed in the manner it was. Mr. Terrill explained that the way most of the carriers do business, the RFP prohibited them from bidding. Representative Carruthers added that the design of the RFP would be discussed later in the meeting by the ADOA staff.

In response to Representative Gullett, Mr. Terrill replied that CIGNA was an AHCCCS provider until October 2003. Under the AHGCCS plan, there are multiple contractors in each area; however, each of those contractors has the full scope of responsibilities.

In response to Senator Martin, Mr. Terrill replied CIGNA must project what the premium rates will be 23 months into the future. They usually take a conservative posture and later negotiate the rate after reviewing current trends.

In response to Mr. Cooper, Mr. Terrill indicated that CIGNA is the strongest provider network in rural Arizona as reported by ADOA.

In response to Representative Carpenter, Mr. Terrill noted that the best savings for healthcare is managing the contract by designing partnerships with doctors to deliver good medicine. It is also important to have the consumer engaged in the healthcare process.

Betsey Bayless, Director, ADOA, commented that the ADOA staff will discuss the efforts being made toward self-insurance. She mentioned that the State employee insurance contract is over $400 million, covering 140,000 employees, dependents, and retirees. Ms. Bayless pointed out that the design of the RFP was based on the benefit to the State, as well as the taxpayers.

Frank Hines, Risk Manager, ADOA, clarified that it is not their intention to discredit CIGNA, noting that there are good and bad stories regarding the services received from CIGNA or any other carrier. He maintained that it is good government to be reviewing alternatives for the way the State funds healthcare, wanting the best for the money spent. He suggested that it would be irresponsible not to look at alternatives. ADOA believes it is the right thing to do for the State to become self-insured.

Susan Strickler, Benefits Manager, ADOA, provided a handout (Attachment 3) regarding self-insurance. She explained that 36 other states self-insure all or part of their healthcare plans. In some states, there is a competitive Health Maintenance Organization (HMO) market that the states will use and then self-insure the PPO program. She pointed out that ADOA already self-insures State properties and liability, as well as workers compensation. One of ADOA's goals is to improve choice and program design. She stressed that the RFPs were designed to improve competition and flexibility for the State. Currently, the State has only one contract. If a problem occurred in one area, it would be necessary to bid for contractors who could improve in that area.

In response to Senator Binder, Ms. Strickler replied that most everyone would need to select a new doctor with the self-insured program.

In response to Ms. Gibson, Ms. Strickler answered that Georgia does use the same health model as Arizona is looking to use for self-insurance.

Ms. Strickler continued with her presentation, noting that one of ADOA's goals is to make the process seamless to employees and retirees.

In response to Senator Allen, Ms. Strickler replied that the appeals process is handled through a third-party administrator (TPA).

Ms. Gibson commented that it would be difficult for BC/BS to pay the claims, while someone else managed the medical decisions. Ms. Strickler indicated that it will be necessary to develop good policies and procedures to ensure an effective process.

In response to Senator Allen, Ms. Strickler stressed that ADOA is not looking at creating a bureaucracy, rather they want to implement new programs that will be more user-friendly. Senator Binder indicated that they would like to see a speedy resolution to the appeals process to ensure medical treatments are not delayed.

In response to Representative Aguirre, Ms. Strickler replied that some of the carriers bidding on the RFP have indicated that they recognize the specific needs in the rural areas. In some areas, the State is the only employer.

Ms. Strickler explained that ADOA has received seven network offers in the various regions. Based on this, ADOA feels they can offer at least two HMO equivalents and one or two PPOs in the urban areas, as well as one or two HMO equivalents and one PPO in the rural areas. Currently, the rural areas only have a PPO.

In response to Senator Martin, Ms. Strickler replied that ADOA makes all eligibility decisions pursuant to the personnel rules.

Stan Hovey, State retiree, distributed a handout (Attachment 4) on long-term care partnership. He provided an overview of a program that is currently operating in four states, which he feels would be beneficial to Arizona. He pointed out that the Robert Wood Johnson Foundation sponsored a partnership that includes California, Connecticut, Indiana, and New York. He explained that the state Medicaid agency agrees to protect a certain portion of an individual's assets when they purchase a long-term care insurance product. The partnership provides an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long-term care insurers.

In response to Senator Allen, Mr. Hovey replied that Mr. Peterson of Pennsylvania is the main sponsor of the Congressional Bill HR 1406.

There being no further business, the meeting was adjourned at 11:22 a.m.

Respectfully submitted,

Carol Dager

Carol Dager
Committee Secretary

(Tapes and attachments on file in the Secretary of the Senate's Office/Resource Center, Room 115.)

AHCCCS

Arizona Health Care Cost Containment System

11 6 2003

The New York Times, August 7, 1991

Late Starter in Medicaid, Arizona Shows the Way

By ERIK ECKHOLM

TUCSON, Ariz. — When Jessica Bejarano's 3-year-old son, Sergio, had headaches and a fever on a recent morning, she took him to their family doctor at an attractive pediatric clinic. The doctor took a blood count, and though he suspected a routine viral infection he had them return the next day for another test, just to make sure.

For most Americans, an ordinary medical encounter. And that is what was so exceptional. Mrs. Bejarano, who is 26 and unemployed, and her two sons are patients in Arizona's version of Medicaid, the Federal-state medical program for poor people.

Shaping a Giant Manager

In much of the country, patients like Mrs. Bejarano and her sons have covers only the very poor, excluding many people who just cannot afford health insurance. But for those who are included, the program, unlike others, is run like a giant health maintenance organization. Every patient joins a "managed care" plan, a group of doctors and hospitals that receives a fixed monthly sum for each patient. Every patient has a personal doctor.

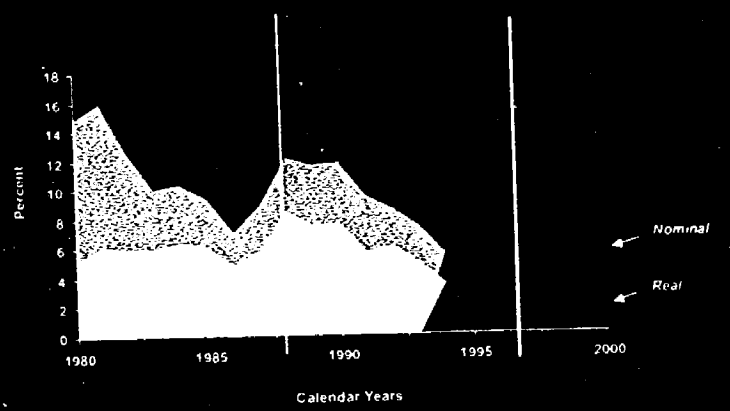
The medical care is unremarkable. Patients are happy, doctors are happy and costs per patient are about 5 percent lower than in other states where the quality of care is often worse.

"It may save a little more money, but more important, they are providing worthwhile [illegible]

11 6 2003

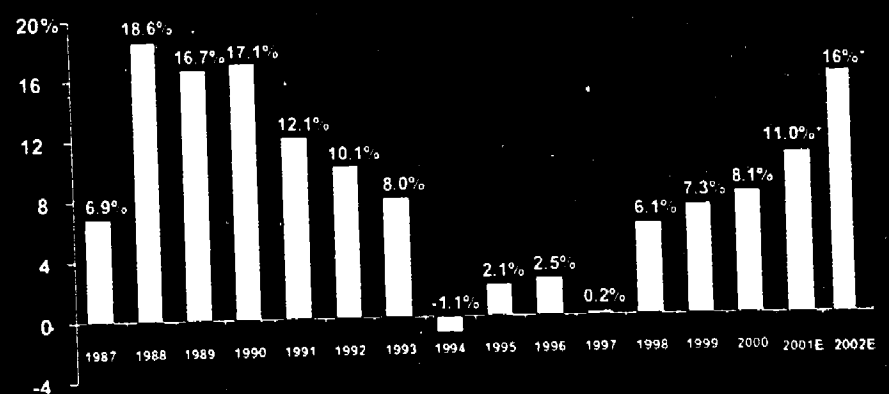
Growth in National Health Expenditures

Health spending growth slowed between 1993 and 2000 to an average increase of 5.6 percent, about half the rate of increase between 1980 and 1993.



Cost Trends: Health Benefit Cost Inflation

Employers expect health care costs to continue rising



All Employers

* Estimate

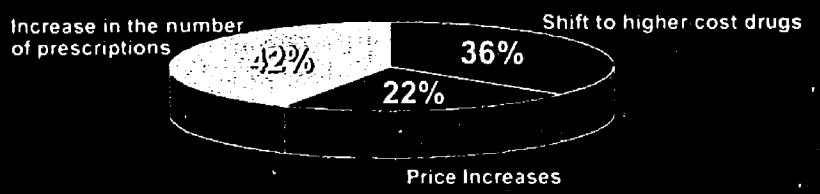
Source: Mercer/Foster-Higgins, 2001

Key Cost Drivers

Prescription Drugs

"Simply put, Americans are demanding, and physicians are prescribing, a higher volume of medicines every year" -- NHCM Report, May 2001

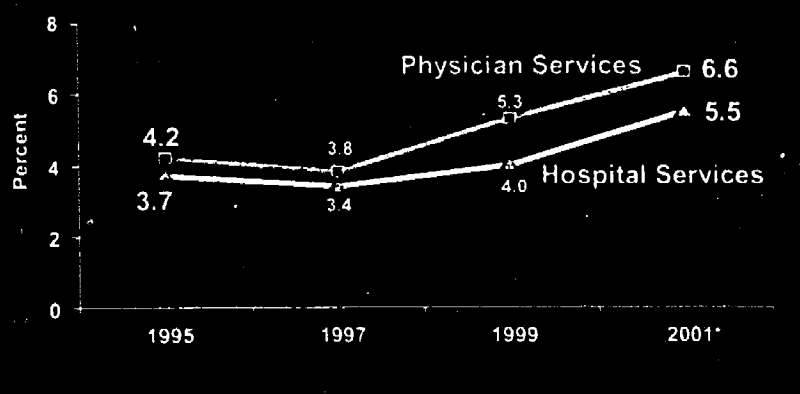
Factors Contributing to the 18.8% Increase in Retail Prescription Drug Spending: 1999-2000



Key Cost Drivers

Hospital and Physician Costs

Average Annual Percentage Change



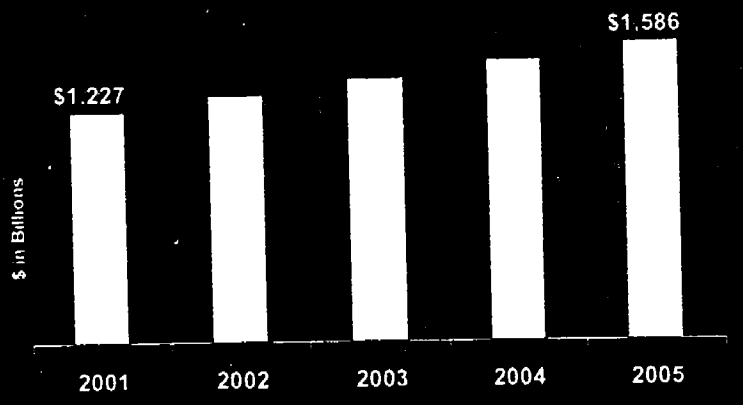
* Projection

Source: Health Care Financing Administration

Key Cost Drivers

Acceleration of New Technology

Increase in Personal Health Spending
Medical Technology Contributes 25%-33% of Increase

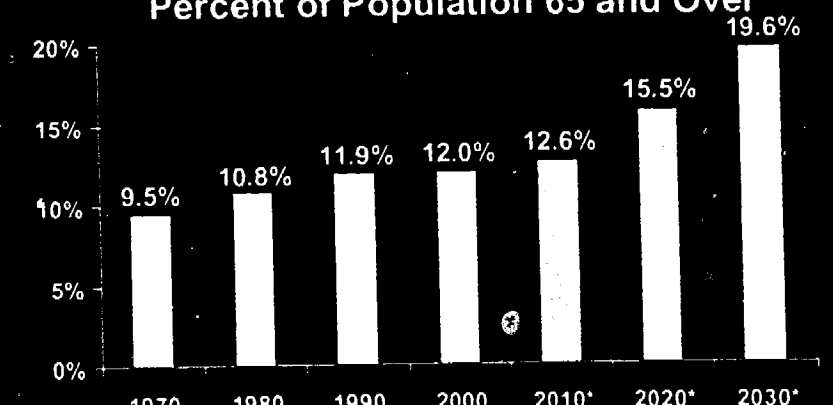


Source: Project HOPE, 2001

Key Cost Drivers

Aging Population

Percent of Population 65 and Over



Living Longer- Consuming More Health Care

* Projection

Source US Census Bureau, 2000

Key Cost Drivers

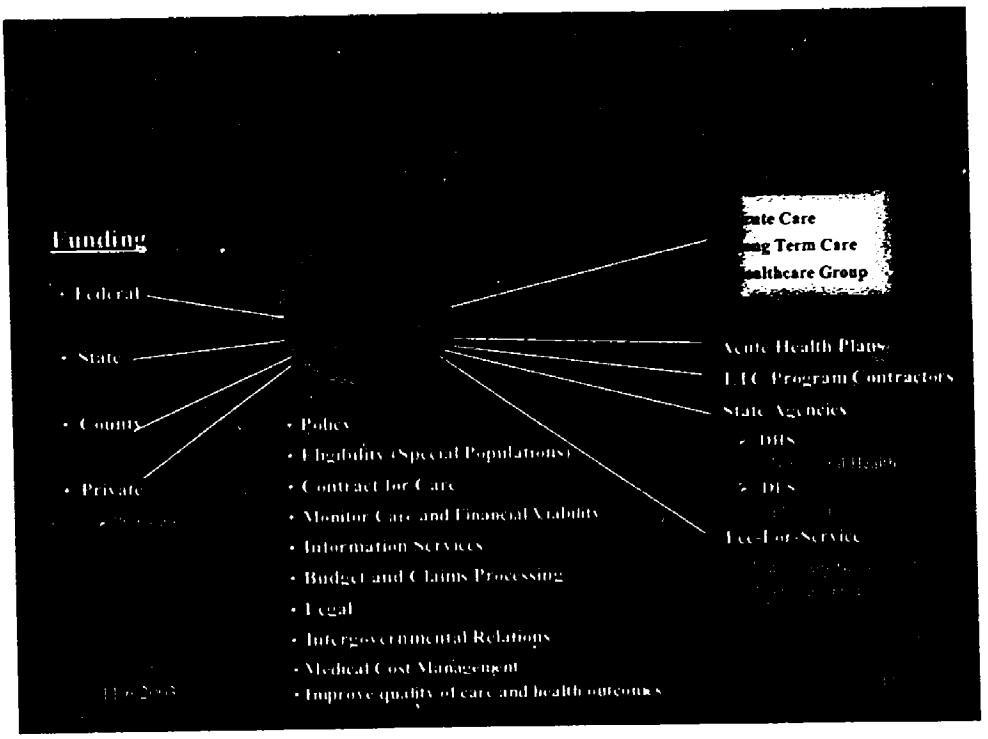
What we see happening

For every one percent increase in premiums 200,000 to 400,000 people lose coverage nationwide

Source The Lewin Group

AHCCCS Today

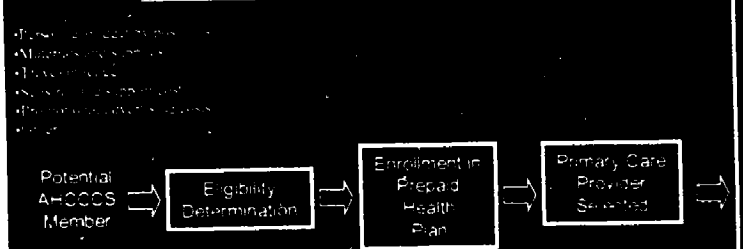
One of Arizona's largest health care insurers



AHCCCS Managed Care

The AHCCCS acute care and KidsCare programs make up a statewide managed care system which delivers acute care services through prepaid, capitated health plans plus Indian Health Service

ACUTE CARE PREPAID MODEL



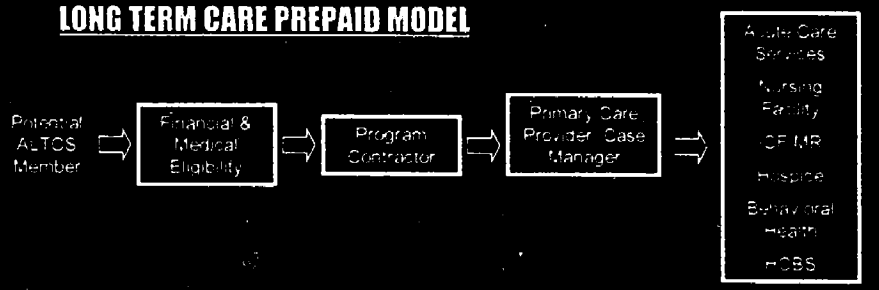
Covered Services

- Outpatient Health Services
- Hospital
- Pharmacy and Durable Medical Equipment
- Laboratory & X-ray
- Specialty Care
- Home Health
- Family Planning
- Behavioral Health
- Dental Services (children full care & adult emergency)

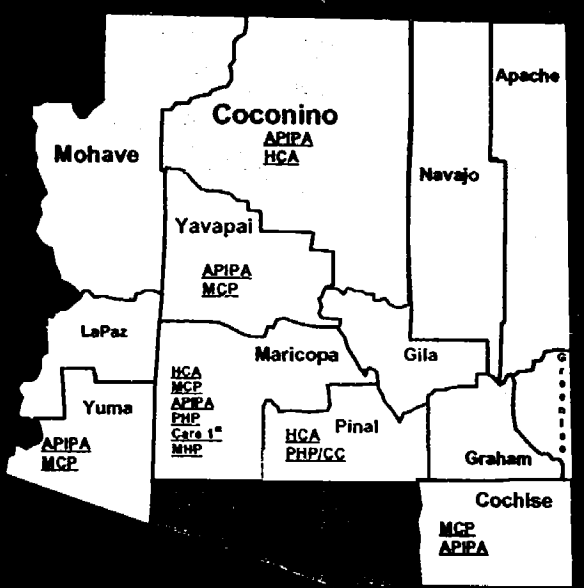
Arizona Long Term Care System (ALTCS) Managed Care

The ALTCS program is a statewide, managed care system which delivers both acute and long term care services through 8 prepaid, capitated program contractors, plus Native American Tribes.

LONG TERM CARE PREPAID MODEL



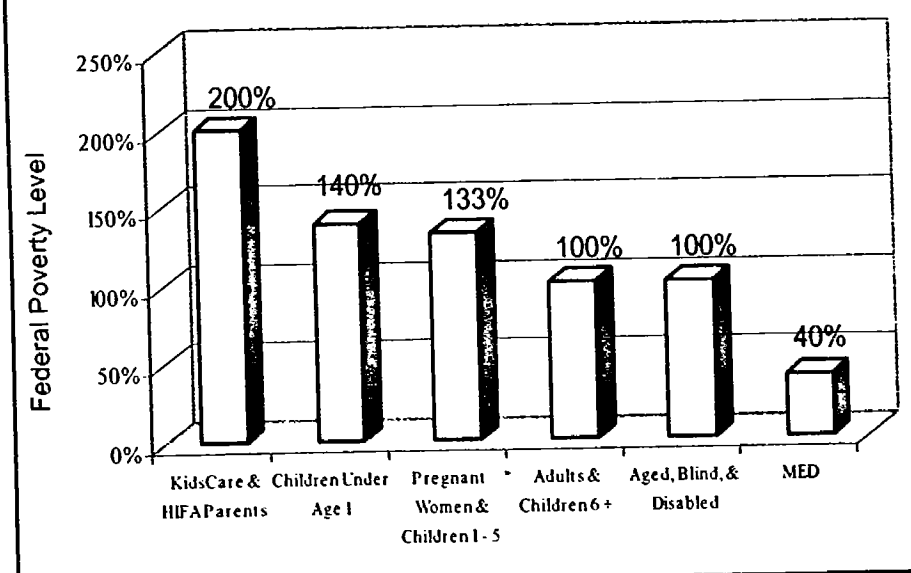
New Acute GSA Effective 10-1-03

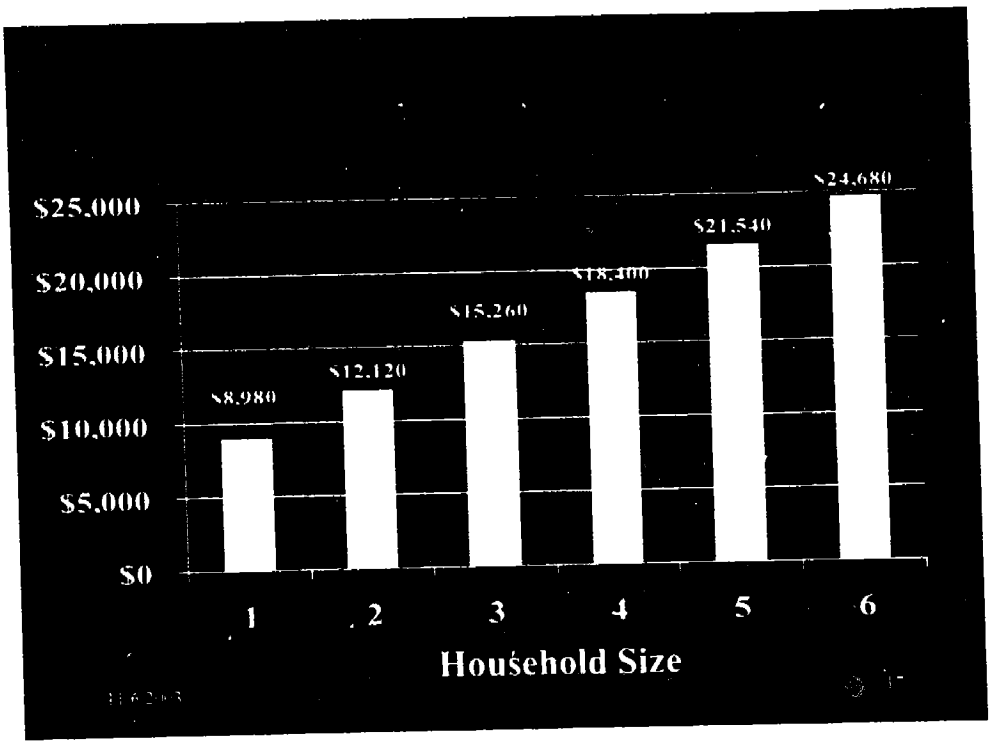


Whom Does AHCCCS Serve?

Program	Enrolled Members	Member Profile
Acute	874,646	Primarily children and women with children. (Includes 106,330 from Proposition 204)
ALTCS (Long Term Care)	38,085	Individuals with developmental disabilities, physical disabilities, or who are over 65 years of age.
KidsCare	50,706	Children through the age of 18.
Healthcare Group	11,250	Employees of small businesses.
Medicare Cost Sharing	18,578	Specified low-income Medicare beneficiaries and Qualified Individuals.
Total	993,265	

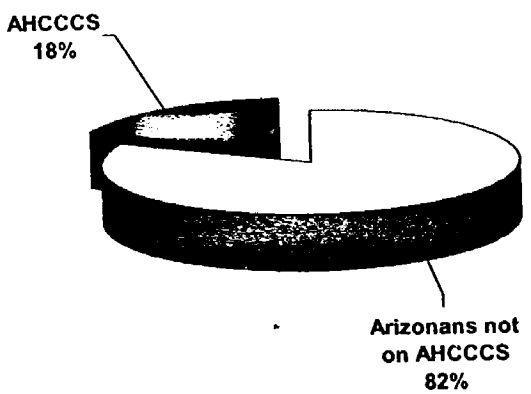
Eligibility Income Levels



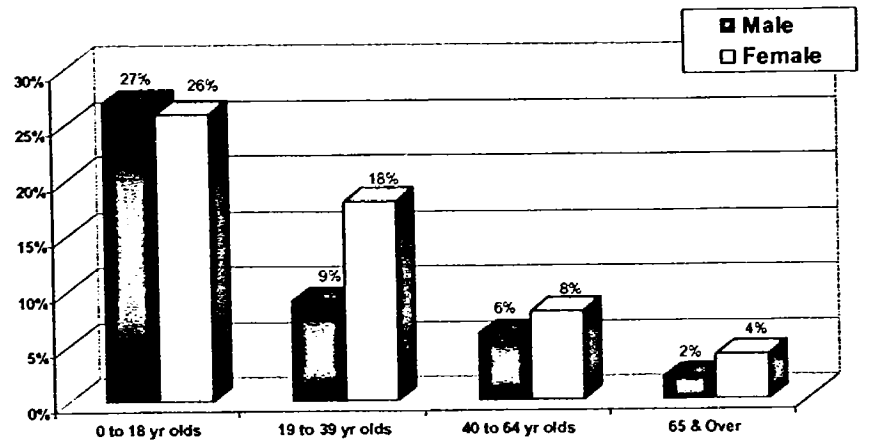


AHCCCS Enrollment

- 993,265 members as of 10/1/03

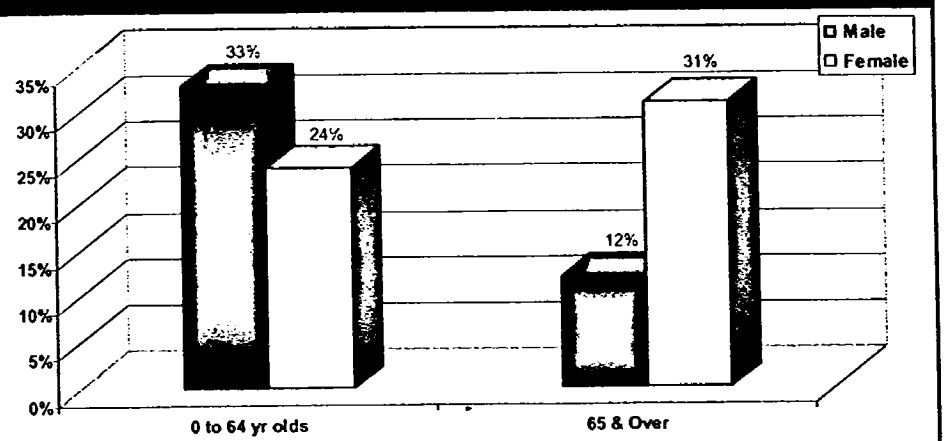


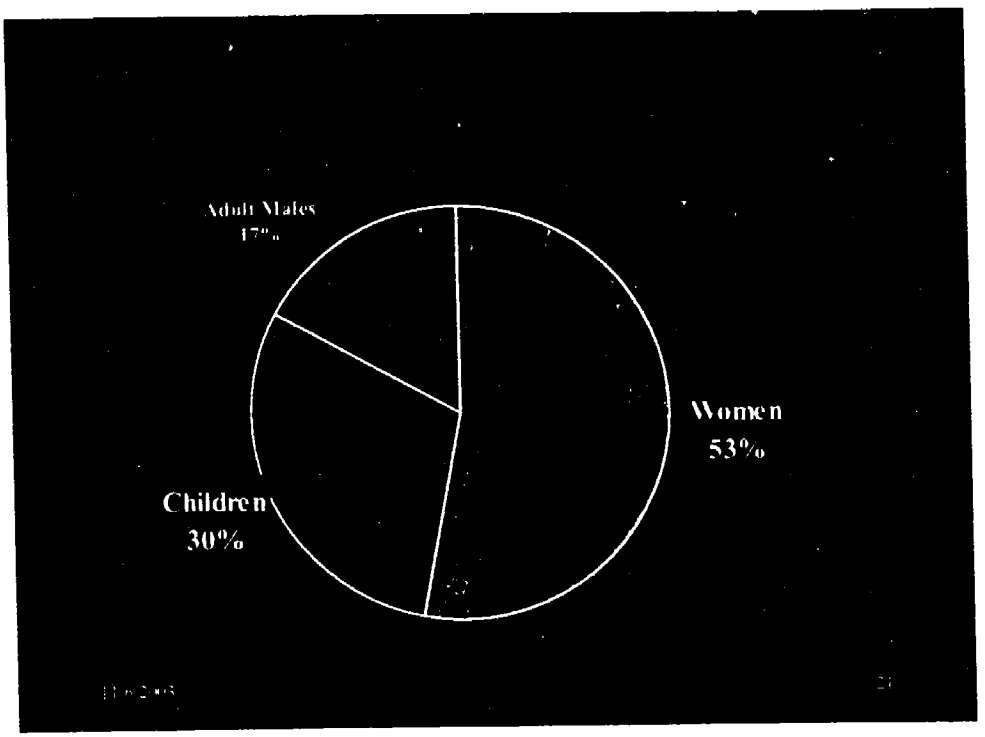
AHCCCS Acute Enrollment By Age and Gender

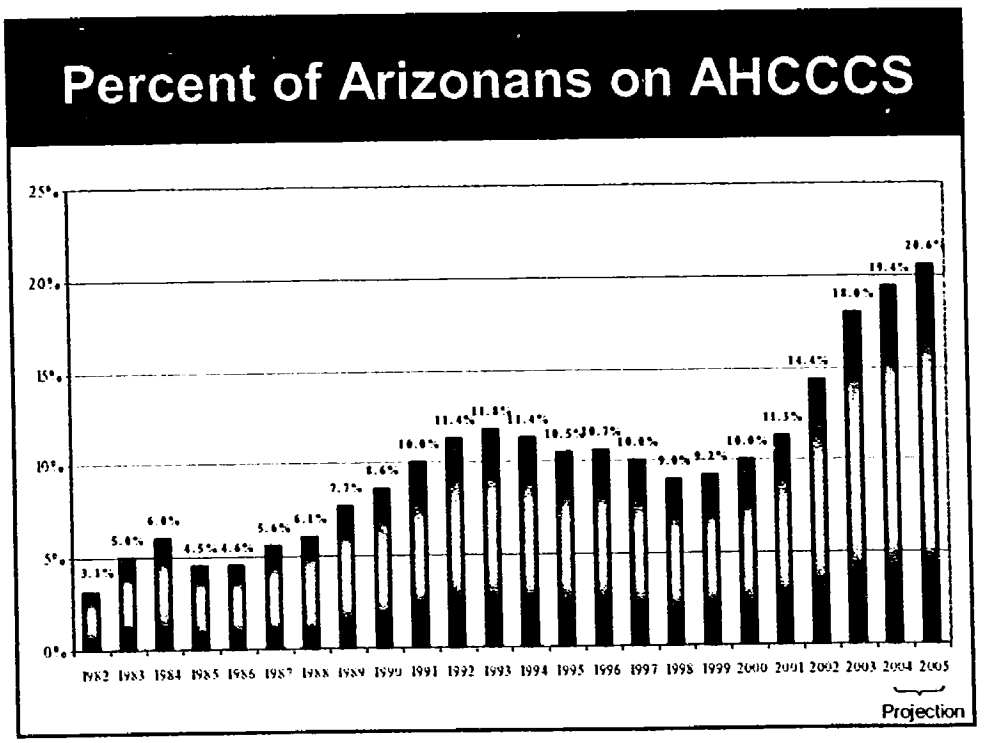


Note: Includes Healthcare Group Members

AHCCCS ALTCS Enrollment By Age and Gender

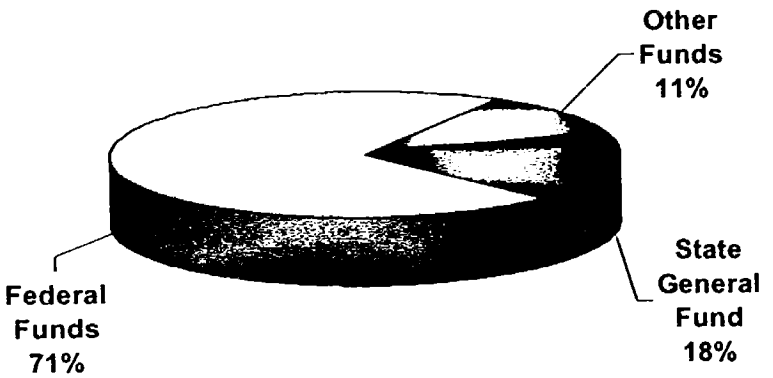


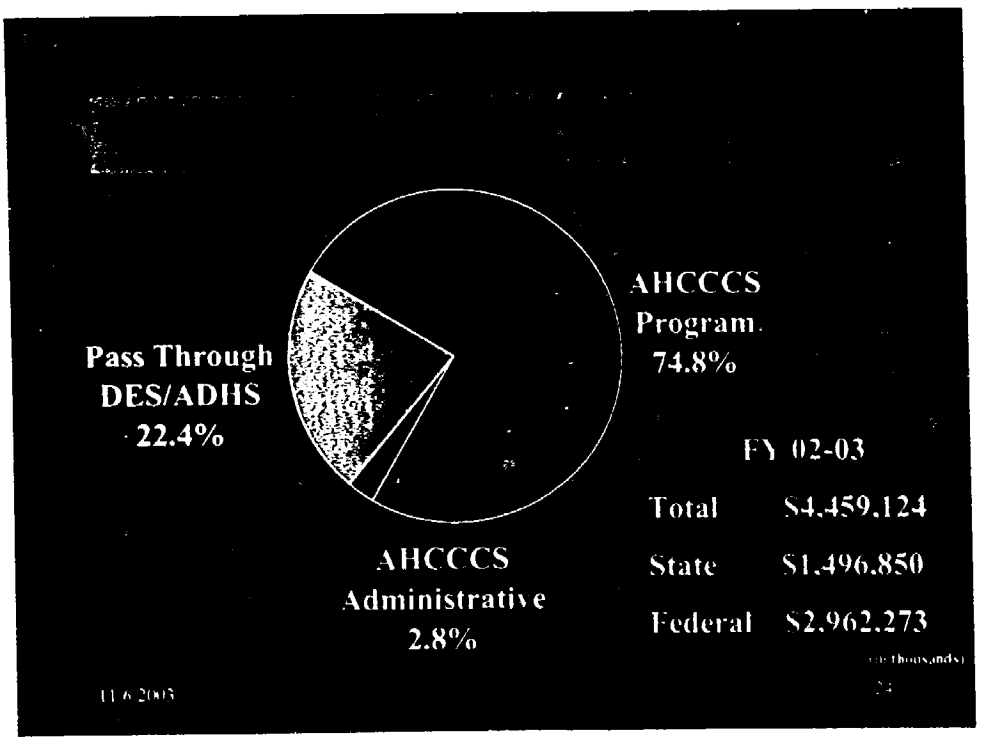

Adult Males
17%
Women
53%
Children
30%

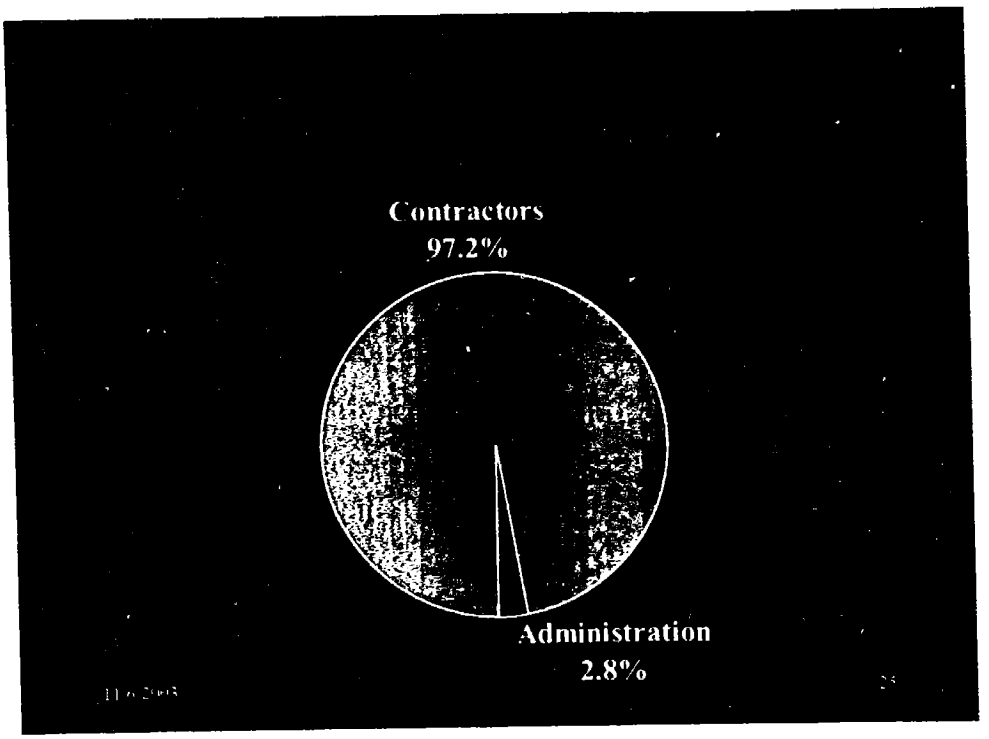

Percent of Arizonans on AHCCCS
25%
20%
15%
10%
5%
0%
3.1%
5.0%
6.0%
4.5%
4.6%
5.6%
6.1%
7.7%
8.6%
10.0%
11.4%
11.8%
11.4%
10.5%
10.7%
10.0%
9.0%
9.2%
10.0%
11.3%
14.4%
18.0%
19.4%
20.6%
1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005
Projection

Revenue Sources By Percent

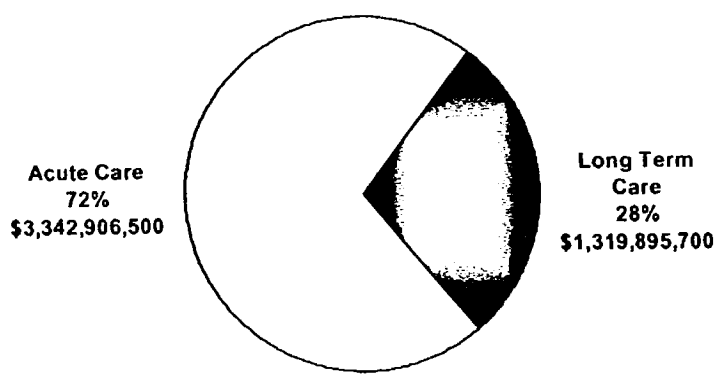
- FY 03/04 budget - $4,012,375,400





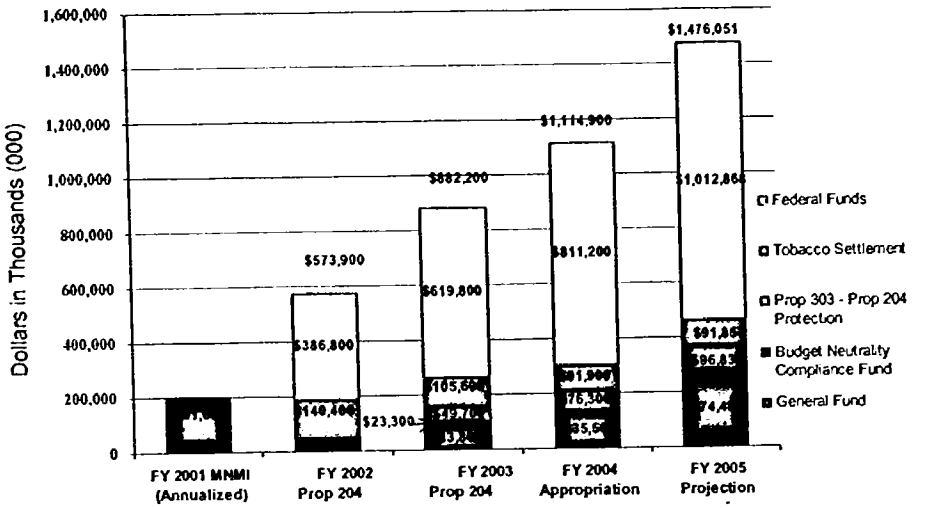


Programmatic Distribution

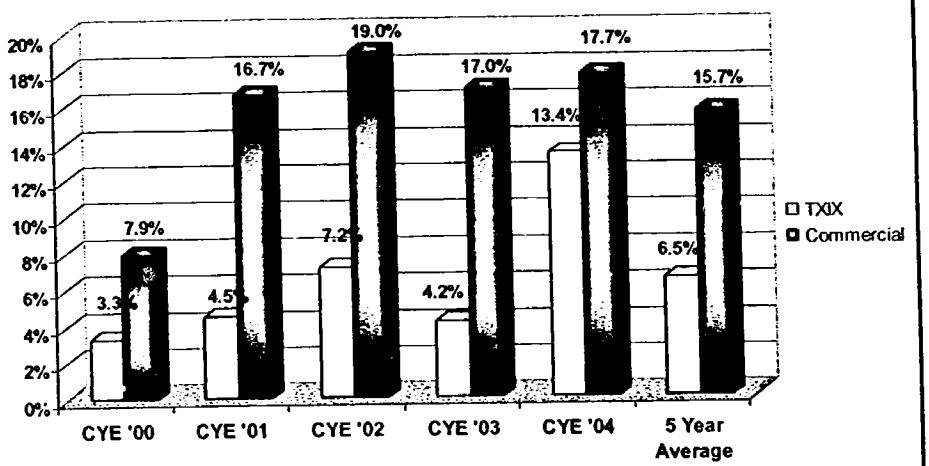


Based on FY04 Appropriation

Proposition 204 Budget Growth



Capitation Trends

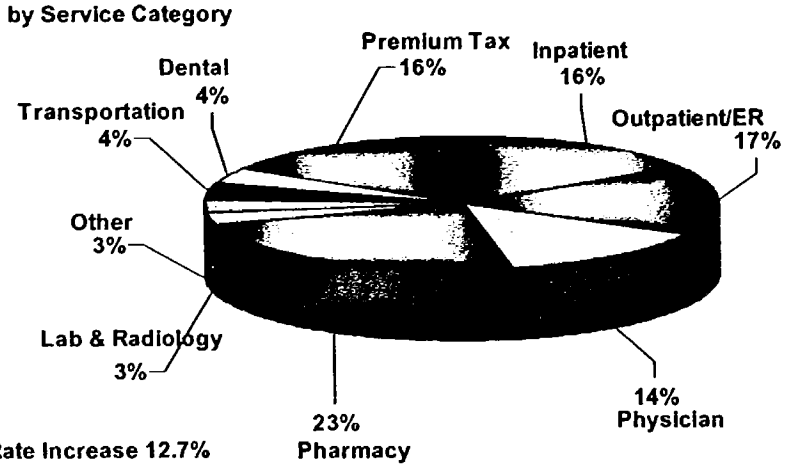


Years 2000-2001 Commerical Increases from the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans--Western region companies with more than 500 employees

2002 Commercial Increase from the Andersen reports estimated increase
2003 -2004 Commercial Increase from the Hewitt Health Recource

CYE 04 Cap Rate Drivers

Title XIX - TANF & SSI
CYE 04 Capitation Rate Impact
Increases by Service Category



Overall Rate Increase 12.7%

- Leadership Award for Medical Quality from American College of Medical Quality
- One of 43 HCFA National Customer Service Awards for collaboration with Native Americans
- Council of State Government Award for Eligibility Fraud Prevention Program

- The first member survey of Medicaid Managed Care in the nation showed that members were very satisfied with AHCCCS health plans.
- On the National Consumer Satisfaction Survey of 400 Medicaid, Medicare, and commercial health plans, AHCCCS health plans were rated at an 85% to 90% satisfaction level by members. This was the highest rating in the nation.

- A recent physicians' and dental survey found that these providers have a more positive image of AHCCCS than commercial managed care organizations.

- In 1995, a GAO report cited AHCCCS for its success in containing costs and access to mainstream medical care.
- In 1996, Laguna Research found that AHCCCS had saved almost $1 billion when compared with other states' Medicaid programs.

- In 2000, Health Affairs cited AHCCCS as one of the few prudent purchasers of health care in the nation.
- In 2002, the Nelson A. Rockerfeller Institute of Government called AHCCCS a "smashing success" and cited Arizona as the "gold standard" for the nation as a model purchaser.
- In early 2003, successfully implemented governor's Prescription Drug Discount Program for seniors.

AHCCCS

Strategic Direction and Focus

11-6-2003 35

Public Policy Focus

Maximizing federal dollars for health care coverage.

Controlling escalating premiums and medical care costs.

Reducing the number of uninsured.

Driving improvement in quality of care and patient care outcomes.

Healthy workforce population health issues.

Assuring stability of the safety net.

11-6-2003

ters o celle

- **Target health care institutions for major services**

Assess and Communicate:

Survival rates
Complications rates
Number of cases
Quality of medical team

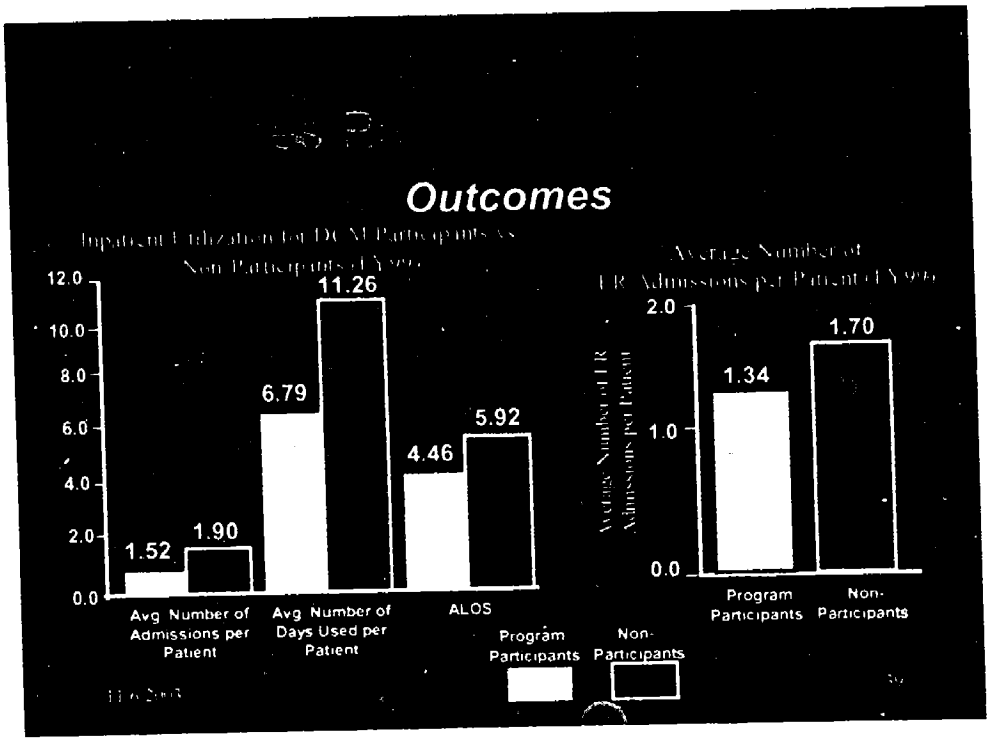
→ Better Outcomes

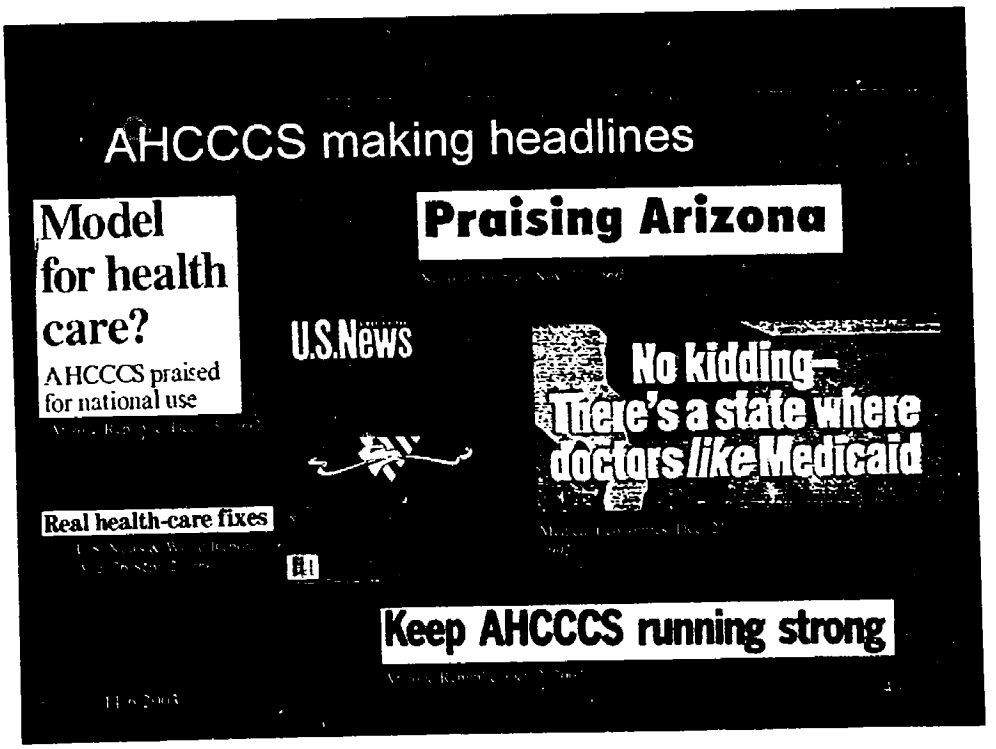
→ Lower Costs

dical Ma agemen

HEALTH SECURITY

- Patient care planners vs. gatekeeper
- Treatment option information
- Targeted medical management
  - Disease management
  - Patient care planning for special need population
  - Preventive care and disease management


Outcomes
12.0
10.0
8.0
6.0
4.0
2.0
0.0
1.52
1.90
6.79
11.26
4.46
5.92
Avg Number of Admissions per Patient
Avg Number of Days Used per Patient
ALOS
Program Participants
Non-Participants
2.0
1.0
0.0
1.34
1.70
Program Participants
Non-Participants


AHCCCS making headlines
Model for health care?
AHCCCS praised for national use
Praising Arizona
U.S.News
No kidding— There's a state where doctors like Medicaid
Real health-care fixes
Keep AHCCCS running strong

Background Information and Discussion Points on the State Employee Health Insurance Program

History

Subsequent to the passage of HB 2600 in 2000, the State declared that the contracted health plans (CIGNA, HealthNet, PacifiCare & United) serving State employees and their dependents were no longer bound to the annual contractual rate caps. Each health plan was asked to provide the financial impact to rates as a result of this legislation. The range was between 9% and 70%, and CIGNA was the lowest at 9%.

The significant adjustment to premium rates attributed to the non-CIGNA health plan membership prompted the State to put the program out to bid in 2000, including a sole-source RFP. CIGNA was awarded a contract of up to seven years (renewable by the State annually), effective October 1, 2001 based upon factors identified by ADOA including:

- Most financially attractive ($16 to $97 million less than the other viable options)
- Highest employee satisfaction (90%) among the existing health plan options
- Highest clinical quality ratings
- Largest and strongest urban and rural provider network

CIGNA was praised by the ADOA Director for providing an affordable and quality option.

The contract was renewed for a second year with a 15% (composite) rate increase, and most recently renewed for a third year effective October 1, 2003 at a 13% (composite) rate increase. There is presently an administrative dispute between ADOA and CIGNA pertaining to the October 2003 rate increase. These increases were *less than* the medical inflation rates projected for the covered population.

During 2002 and 2003, the concept of self-funding by the State was evaluated by ADOA and continues to be investigated as an option to the current form of the program with CIGNA. However, there was significant legislative debate relative to the merit of pursuing such an option. Ultimately, this caused the Legislature to pass bipartisan legislation (HB 2025) last February to postpone any attempt to go to self-funding until October 1, 2004 at the earliest.

Points to Ponder

1. **Why would the State consider self-funding?** Typically, and employer weighs the risks and benefits of self-funding compared to insured arrangements.

The principal risks include:

- significantly greater financial exposure (claims, reserve adequacy, administrative expense)
- less predictability of expense and harder to budget
- fiduciary role and responsibilities

The principal benefits include:
- cash flow gain
- State premium tax savings
- State benefit mandates exemption

2. Would the State save money by converting to a self-funded program? To answer this question, one must know what the CIGNA renewal will be for October 2004 and compare to what is estimated to be total expense under a proposed self-funded program. As of yet, ADOA has not disclosed what the cost projections are for going to self-funding, nor does it have CIGNA's October 2004 renewal rate maximums which are due November 15, 2003.

The current contract with CIGNA provides many of the benefits associated with self-funding including:

a) *Cash Flow Gain*
CIGNA provides the State a 2-month premium deferral and a 15-day payment grace period generating 75 days of "float." This arrangement produces far greater cash flow gain than a standard self-funding arrangement that may yield 15 to 20 days float. If the State switches to self-funding, it will have to "catch up" on this liability at the end of the CIGNA contract, putting the State in a negative cash flow position. The value of the float, assuming 1.75% earned interest, under the CIGNA contract is approximately $2 million compared to a traditional self-funding value of approximately $700,000.

b) *Experience Rating*
The PPO coverage is experience rated and represents approximately 25% of the State's annual expenditure with CIGNA. If claims and expenses are *less* than the fully insured amount, CIGNA is obligated to refund the State such amount. However, if claims and expenses are *greater* than the fully insured amount, the State benefits by only being obligated for the fully insured limit (on a deficit carry-forward basis).

The other benefits associated with self-funding that will not or are unlikely to materialize in this instance include:

c) *State premium tax*
Savings achieved under the health benefits program will be at the expense of the State's General Fund and therefore the 2% tax savings will be matched by a reduction in State revenue.

d) *State insurance mandates exemption*
The fact that the State's own program will be totally exempt from the insurance laws that the State has legislated to apply to all other health insurance products provided by Arizona health plans, may create employee morale issues and public relations problems. Examples of popular consumer-oriented mandates include independent health care appeals, coverage mandates such as cancer treating drugs and clinical trials, chiropractic care, Rx formulary rules, and prior approval of advertising. State employees will also lose the protections of Arizona's strong

insurance regulations – most notably financial and solvency protections – because the vendors serving the State will not be under the jurisdiction of Arizona's Insurance Department.

e) Provider payment protections
Likewise, physicians, hospitals, and other providers will lose the timely payment of claims protections that the Legislature has enacted, if the State elects to pursue self-funding.

3. Knowing that the ADOA is actively pursuing a self-funding arrangement, did "best in class" vendors bid on this program? No, the list of *those who did not bid* (and would be unable to serve the State if contracts under the current RFP are awarded) includes a number of top companies. Besides CIGNA, the non-bidding list includes Aetna, United, PacifiCare, Health Net, and Humana. Because of the non-integrated design of ADOA's bid specifications, all these health plans – plans that serve the largest private employers in Arizona and in the United States – declined to bid. Another major insurer, Blue Cross, only bid on one component of the State's RFP.

ADOA has already found it necessary to re-bid portions of the RFP, but that may not be enough. A complete revisiting of the bid specifications is needed, at a minimum, if true "best of class" vendors are to be attracted to the program.

4. Is the CIGNA provider network inadequate? No, in fact it is very strong, and was determined to be the largest and strongest provider network by ADOA when the current contract was awarded. There are currently 1479 primary care physicians, 4774 specialists, and 52 hospitals under contract statewide. Applying the State's contract specifications, only 52 State members of the 123,000 total do not fall within the State's desired provider access measure under CIGNA's contract. Moreover, CIGNA has achieved the highest accreditation ratings with the National Committee on Quality Assurance (NCQA), an independent accreditation organization that reviews and evaluates health plans nationwide on a wide variety of provider quality measures. Contrast that with those of the vendors currently bidding – many have not achieved the same level of accreditation.

Also, the CIGNA Medical Group is exclusively available via CIGNA and has been chosen to be the provider of care by nearly 25,000 State members.

5. Are the other provider networks more competitive, from a cost standpoint, than CIGNA's? According to an independent study and analysis performed by Hewitt Associates, the answer is No. CIGNA's unit cost (under its provider contracts) is lower than its rivals, making CIGNA more competitive. The Hewitt database for Arizona includes Arizona Foundation for Medical Care, Aetna, CIGNA, Great West, Humana, PacifiCare, PHCS, Principal and United (Arizona Foundation and Great West were bidders for the State's RFP for the medical network). CIGNA's competitive advantage over the other networks for an EPO/POS type plan design averaged 14% and for PPO it averaged 18%, including physician, outpatient and hospital expenditures. This advantage is substantial. By way of example, if CIGNA's unit cost were to increase to the competitors' average (i.e., 14 points for EPO/POS), the added cost to the State would be $56 Million per year.

6. **Would the State achieve the same high level of cost savings on pharmacy benefits by carving out the drug coverage, as would happen under the self-funding program?** That is highly unlikely, for two reasons. One, CIGNA's net unit costs for prescription drugs are very low in comparison to most pharmacy benefit managers ("PBMs"), due to the national buying power CIGNA has. Second, the utilization of lower cost generic drugs is far higher at CIGNA than those PBMs can achieve, because CIGNA has its own pharmacies that fill millions of prescriptions annually and it treats a large number of State employees through the CIGNA Medical Group (with doctors who are employees). A recently completed study for AHCCCS by the Lewin Group supports this conclusion -- it warns of the financial risks to the State of carving out prescription drugs under the AHCCCS program.

Also, CIGNA does not make a margin (mark-up) on the prescriptions provided by the retail pharmacies participating in the network -- a practice among PBMs that is well-documented and reported in a recent *Wall Street Journal* article profiling Express Scripts and PCS (two of the PBM bidders the State is considering).

7. **What happens to the nearly 12,000 State employees and dependents who are in active disease management programs?** They will lose their providers and will have to start all over with new ones. CIGNA Medical Group case managers, nurses and other caregivers will not be included in the self-funded medical networks the State plans to create. Presently, the following number of State members are actively engaged in CIGNA's disease management programs, by type:

Asthma:	4,298
Diabetes:	3,535
Low Back:	2,071
Cardiac:	1,513
Total	11,417

Continuity of care management should be a major concern regarding these nearly 12,000 State members who have established a routine and process with their CIGNA case managers.

Moreover, the prevalence of disease in the Saguaro plan has been documented to be greater than CIGNA's national average. For asthma it is 5% vs. 3.1%; for diabetes it is 4% vs. 2.9%; for low back it is 2.5% vs. 2.5%; and for cardiac it is 1.8% vs. 1.6% (Saguaro plan vs. CIGNA national average in disease prevalence, respectively).

Despite these higher disease prevalence rates, CIGNA has achieved a remarkable 9.3% penetration/participation rate with documented savings to the State, compared to CIGNA's Arizona averages, as follows:

- $995,421 direct medical expense savings
- $583,998 indirect productivity savings

ADOA claims that their new self-funding plan will improve program design ("Offerors proposed new, innovative disease management programs customized to State employee needs"). While

sales promises are fine, actual results are what matter. CIGNA has proven its ability to offer cost-effective, innovative disease management programs for the four disease states noted above, with a fifth (pulmonary disease) currently being launched.

8. Has the State truly considered the unique qualities of the CIGNA Medical Group?

The CIGNA Medical Group ("CMG") is exclusively available via CIGNA and has been chosen to be the provider of care by nearly 25,000 State members. Here are some important features of the CMG:

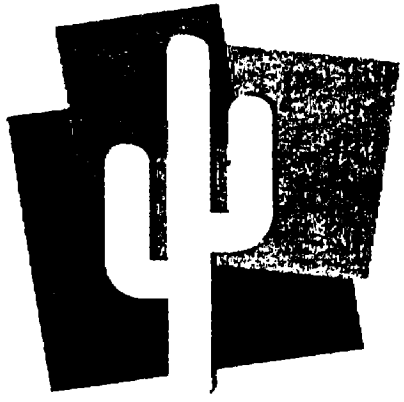
- In the past year, 837 State members have enrolled and completed CIGNA's Diabetes Education Class. This award winning class is certified by the American Diabetes Association, as a result of its effectiveness in educating patients about their disease, and their role and responsibility in personal care management.
- There were 12,029 patient visits by State employees in the CIGNA Medical Group's After Hours Centers in 2002 and 9,152 patient visits through September 2003 (on pace for a 20% increase). The After Hours Care Centers are an alternative place of service to emergency rooms and provide more timely care with 50% less triage to the ER (when compared with independent urgent care providers such as NextCare). How will Arizona's overcrowded ERs handle this extra load?
- On-site pharmacy services at CIGNA Centers assures a high rate of generic utilization that has approached 70% and improved quality relative to compliance in getting prescriptions filled and following the course of treatment.

Continuity of care should be a great concern for the 25,000 State members who have chosen the CIGNA Medical Group physicians over the private practice physician community and are utilizing the unique services made available by CMG. These unique services and the physicians who provide them will not be available under the self-funded program being created by ADOA.

ADOA
Arizona Department of Administration

MERCER
Human Resource Consulting

THE SAGUARO PROGRAM



FOR YOUR BENEFIT

Self-Insurance

Maximizing the value of health benefits for State employees and retirees through improved provider choice and program design.

Arizona Department of Administration
Mercer Human Resource Consulting

CIGNA Renewal Percentages

Initial contract signing with CIGNA for first year: $290 million

- First Renewal:
  - Requested: 30% increase
  - Negotiated: 19% increase
  - Total Paid: $350 million

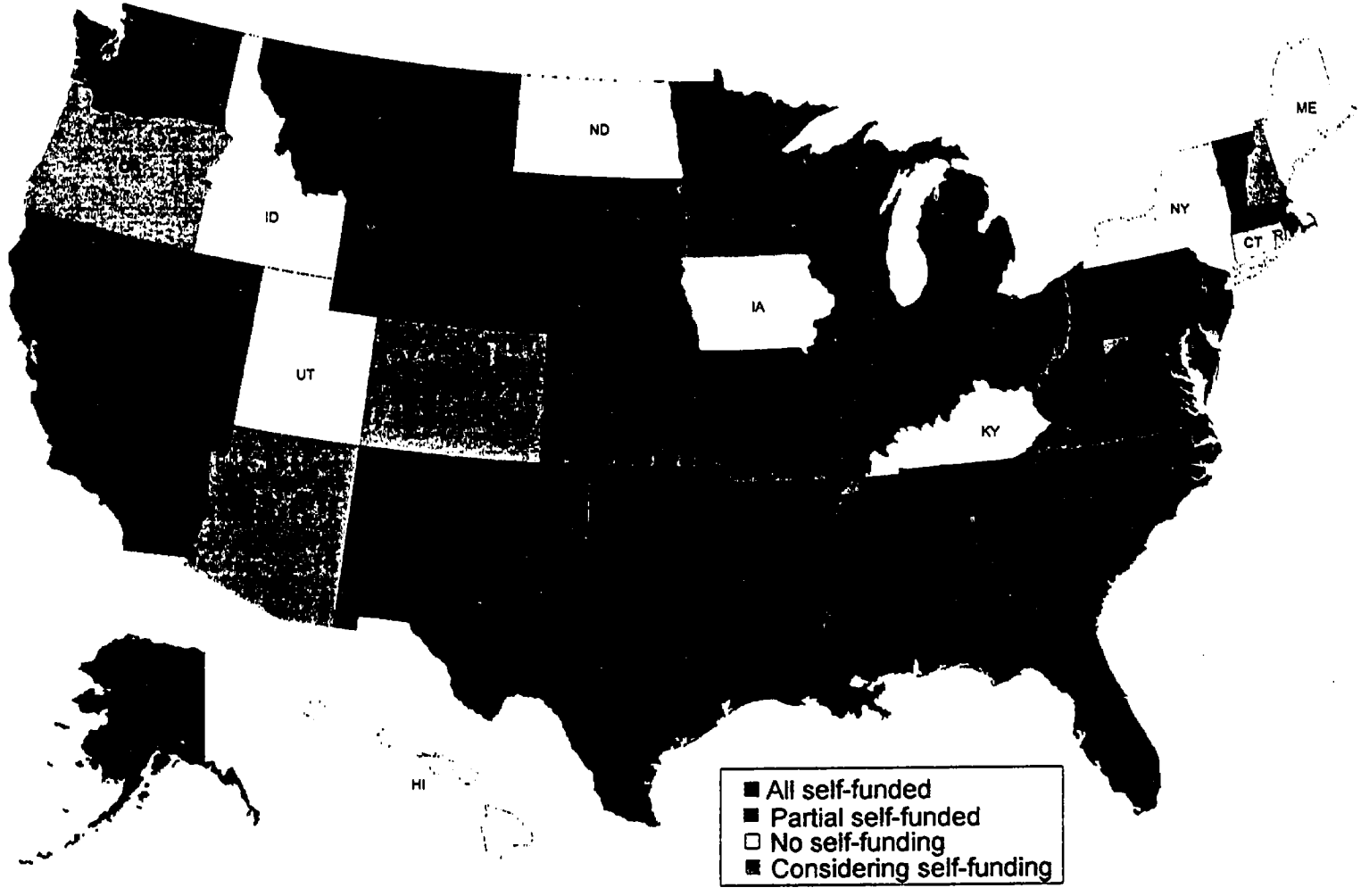
- Second Renewal:
  - Requested: 23% increase
  - Implemented: 13% increase
  - Total Paid: $402 million

CIGNA received $36 million for administrative costs and $37 million in profit and risk charges in FY '03.

TOTAL CONTRACT INCREASE FROM INITIAL YEAR TO CURRENT YEAR — $112 Million

What Other States Do

Self-funding of State Employee Health Plans



ADOA Experi nce/Expertise in Self-Insurance

Risk Management

- Property and Liability: **Self-insured since 1976**
  - FY '03 — 8,551 claims for a paid total of $33.6 million

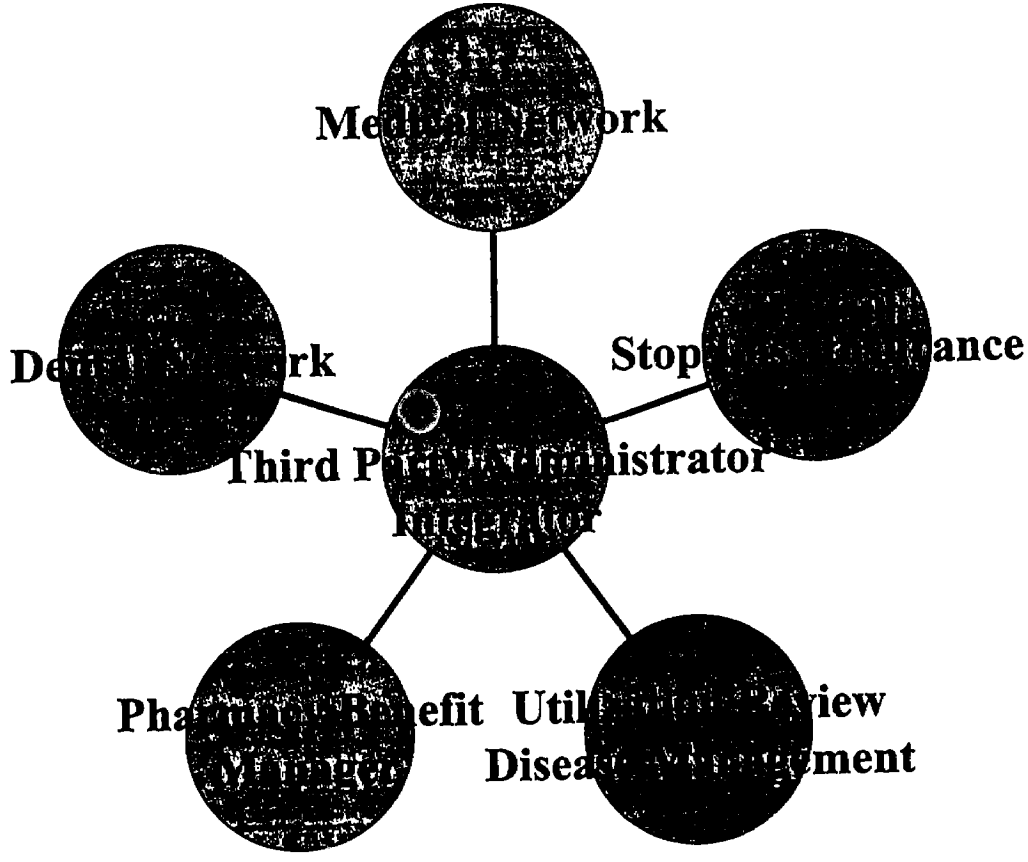
- Workers Compensation: **Self-insured since 1994**
  - FY '03 — 4,638 claims for a paid total of $17.9 million

Goals of Self-Insuring

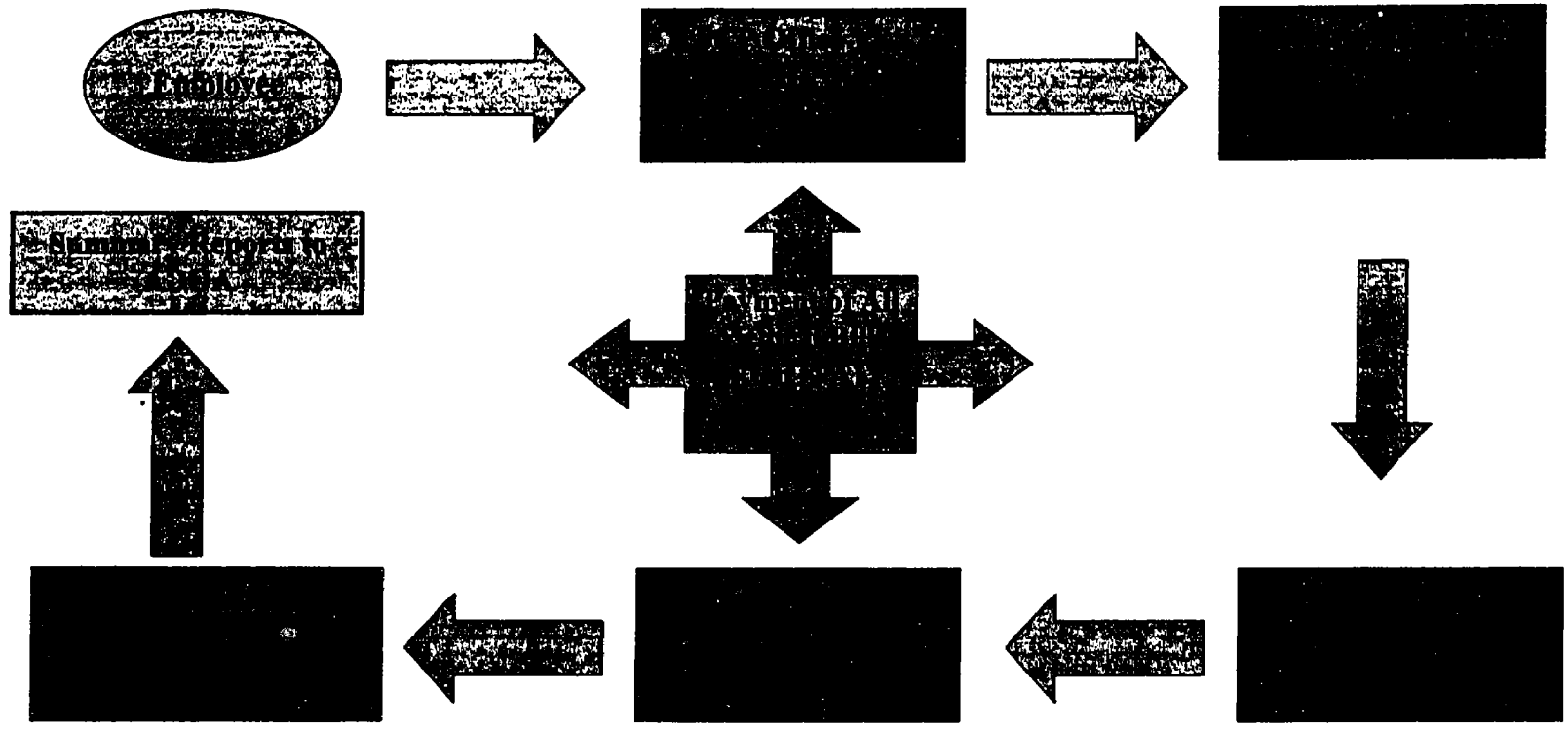
Maximize value of health benefits to State employees through improved choice and improved program design

- Employees: *Improved CHOICE*
  - Increased Choice in Providers
  - Improved Choice in Plan Design
- State: *Improved PROGRAM DESIGN*
  - Better understanding of treatment patterns to develop customized program
  - Increased flexibility over program decisions

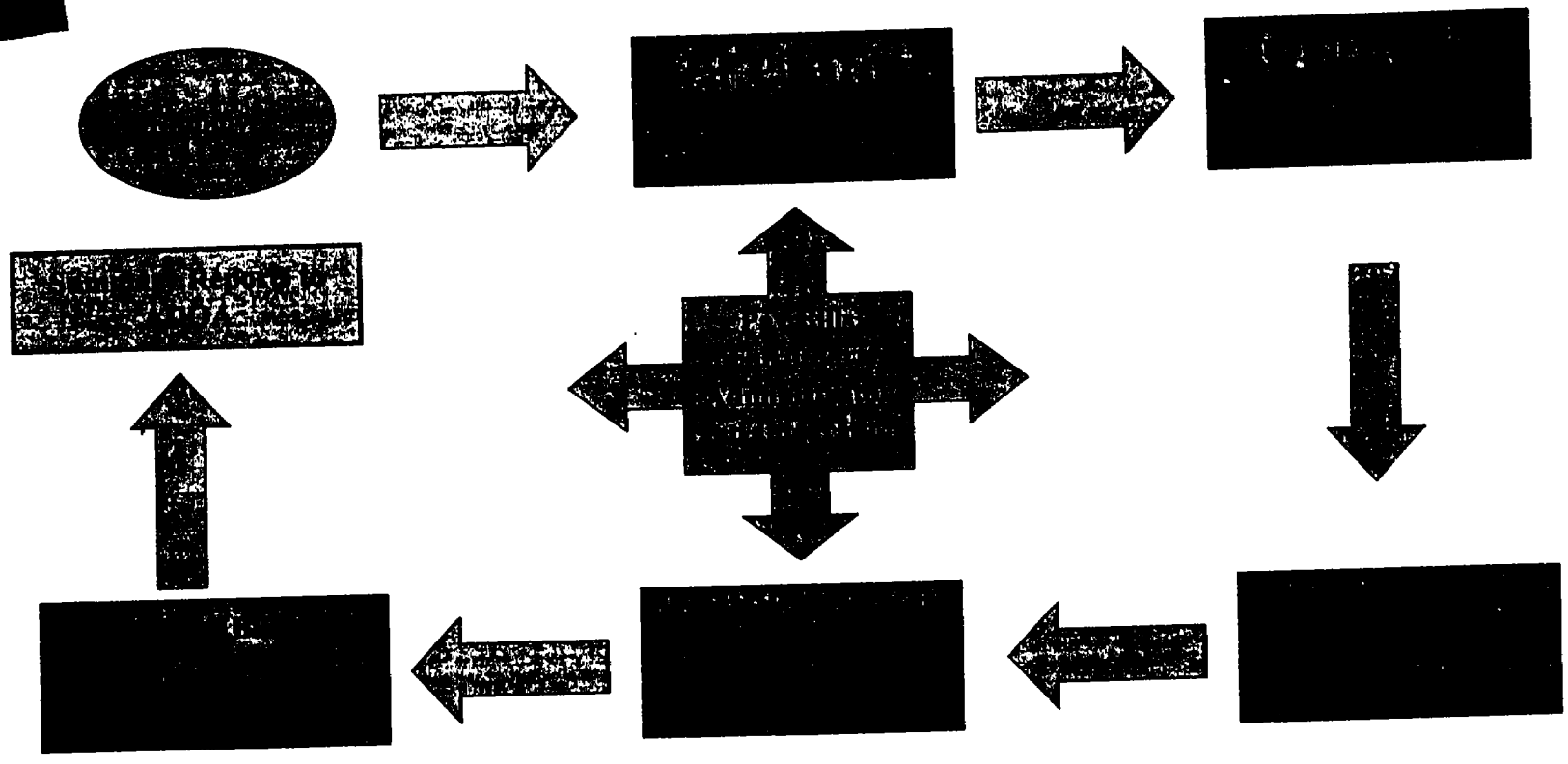
Program Structure: Integrated Services



How Employees Access Medical Care with CIGNA



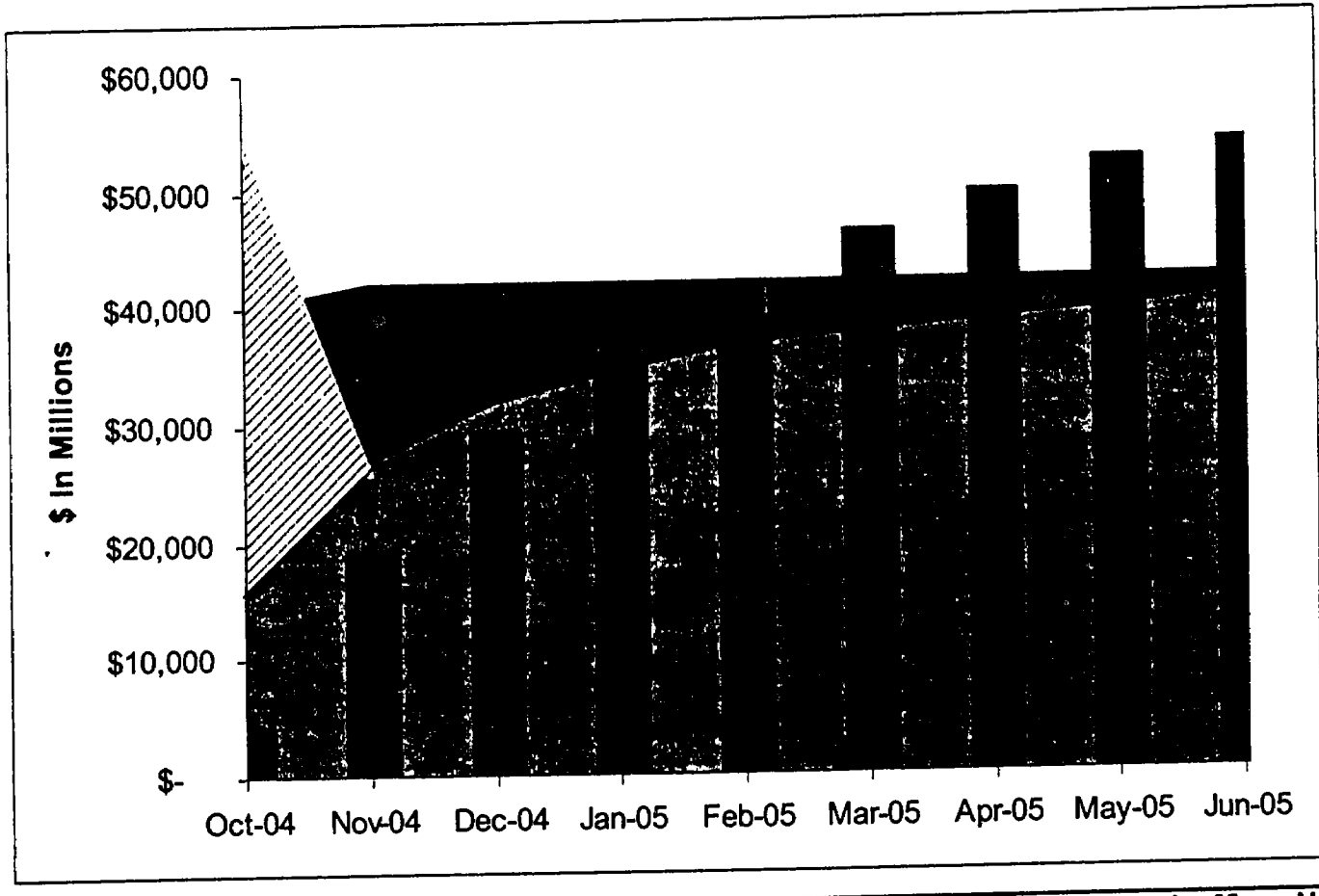
How Employees Access Medical Care with Self-Insurance



Goals of S If-Insuring: Reality

Goals	Reality
Improved Choice	▪ Network - 7 Offerors ▪ Contracting - Anticipate: 2 EPO's/1-2 PPO's Urban Areas 1-2 EPO's/1 PPO Rural Areas ▪ Best Network by Service Area
More Docs/Hospitals = More Choice and Better Access	
Improved Program Design	▪ Offerors proposed new, innovative disease management programs customized to State Employees ▪ Offerors guaranteed admin fees and credits/assistance for up to 3 years ▪ Offerors are Best in Class in their Industry
Innovative/Best in Class Vendors = Better Program Design	

Reserve Accrual in the Fund

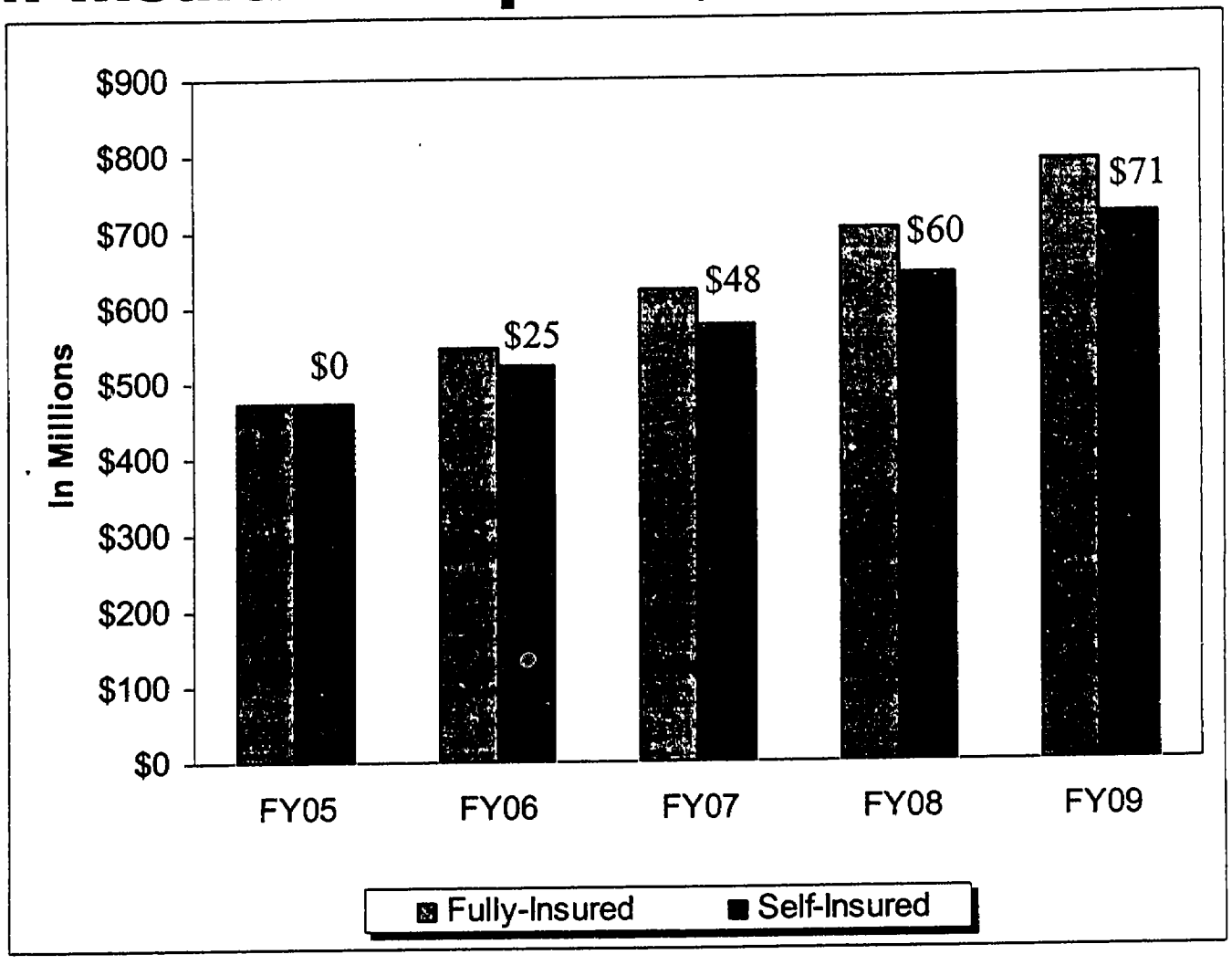


	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05
Beginning Balance	$ 17,047	$ 4,186	$ 19,278	$ 29,364	$ 36,650	$ 41,799	$ 46,223	$ 49,543	$ 52,109
Plus Estimated Monthly Receipts	$ 40,047	$ 42,013	$ 42,013	$ 42,013	$ 42,013	$ 42,013	$ 42,013	$ 42,013	$ 42,013
Minus Estimated Total Expenditures	$ 52,908	$ 26,921	$ 31,927	$ 34,726	$ 36,864	$ 37,588	$ 38,693	$ 39,446	$ 40,590
Equals Estimated Claim Reserve Level	$ 4,186	$ 19,278	$ 29,364	$ 36,650	$ 41,799	$ 46,223	$ 49,543	$ 52,109	$ 53,531

Indicates October 2004 monthly total expenditures includes a lagging CIGNA premium payment of $37.8 million.

* Reserve calculations include medical and dental.

Estimated 5-Year Savings with Self-Insurance Equals $204 Million

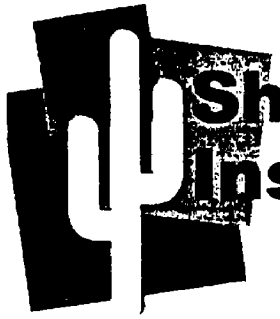


*Values represent savings per year in millions, totaling $204 million over 5 years.

** Values compare CIGNA administration at approximately 19% versus ADOA administration at approximately 14%

Shattering th Myths Related to Self-Insurance

- **The State will need to come up with $80 million <u>immediately</u> for a claims reserve.**
  - **FALSE.** The claims reserve will be built up over time within the Health Insurance Trust Fund. It is estimated the Fund will accrue approximately $55 million by the end of FY '05 and an additional $25 million in FY '06. To ensure financial stability, Stop Loss Insurance will also be purchased to pay large claims over $250,000.
- **No large insurance companies proposed on the program.**
  - **FALSE.**
- **There was a poor response from potential contractors.**
  - **FALSE.** The State received multiple proposals from companies that specialize in self-insured programs. In total, the State received over 20 proposals for services from companies that cover hundreds of thousands of lives in Arizona.
- **State employees will be "dumped" into the AHCCCS program.**
  - **FALSE.**



Shattering the Myths Related to Self-Insurance

- **The State should not take on this financial risk during a budget crisis.**
  - **FALSE.** Thirty-six (36) other states already self-insure all or a portion of their employee program. Most have been self-insured for over 15 years.
  - Nationally, between 1998 and 2002, healthcare premiums rose, on average, 61.3% for fully insured plans versus 42.5% for self-insured programs*. The move to self-insurance will allow the State to reduce rising healthcare premiums for State employees and retirees.
  - Most employers with over 5,000 employees are self-insured because it makes good business sense.

*Kaiser Family Foundation Study- 2002

University of Maryland Center on Aging

Partnership for Long-Term Care

UMCA

Approximately 40 percent of the 65-and-over population will eventually need long-term care, with an average stay of 2.5 years at a cost ranging from $30,000-$65,000 annually. And although many elderly Americans still believe that their long-term costs will be covered by Medicare, the truth is that only after spending down to impoverishment will they receive public support through Medicaid.

The Partnership for Long-Term Care provides an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long term care insurers. Participating states work with insurers to create insurance policies that are more affordable and provide better protection against impoverishment than those commonly offered. Once private insurance benefits are exhausted, special Medicaid eligibility rules are applied if additional coverage is necessary.

The authority for instituting the Partnership for Long Term Care (PLTC) program resides in state plan amendments rather than Centers for Medicare and Medicaid Services (CMS) waivers. There is a provision in Medicaid law that allows a state to alter the asset eligibility criteria dependent on a state specified requirement. In this case, it is the purchase of a state certified long term care insurance policy.

The Partnership is sponsored by The Robert Wood Johnson Foundation.

Partnership Update

- Overview
- Fact Sheet
- OBRA 1993
- Replication Activity
- Publications
- Participating Insurers
- Contacts

Partnership Presentation

- Partners In Social Marketing

Related Links

- California
- Connecticut
- Indiana
- New York

Questions and comments regarding the Center on Aging can be directed by E-mail to speters@wam.umd.edu

UMCA Homepage

Last Updated 10/24/02

LONG TERM CARE PARTNERSHIP

HOW IT WORKS: DOLLAR FOR DOLLAR MODEL

CASE # 1

- I HAVE $100,000 AMOUNT OF ASSETS TO PROTECT
- I BUY A $50,000 POLICY BENEFIT
- I MUST STILL SPEND DOWN $50,000 OF ASSETS, BUT $50,000 IS PROTECTED

CASE # 2

- I HAVE $100,000 AMOUNT OF ASSEETS TO PROTECT
- I BUY A $100,000 POLICY BENEFIT
- I HAVE ZERO AMOUNT OF ASSETS TO SPEND DOWN, $100,000 IS PROTECTED

CASE # 3

- I HAVE $300,000 AMOUNT OF ASSETS TO PROTECT
- I BUY A $100,000 POLICY BENEFIT
- I HAVE $200,000 AMOUNT OF ASSETS TO SPEND DOWN; $100,000 IS PROTECTED.

CASE # 4

- I HAVE ZERO AMOUNT OF ASSETS TO PROTECT
- I BUY A $50,000 POLICY BENEFIT
- I HAVE ZERO AMOUNT OF ASSETS TO SPEND DOWN: NO ASSETS ARE PROTECTED BECAUSE I DIDN'T HAVE ANY

HOW IT WORKS: TOTAL ASSET PROTECTION MODEL

CASE # 1

- I HAVE $300,000 AMOUNT OF ASSETS TO PROTECT
- I BUY A THREE YEAR POLICY WORTH MORE THAN THE STATE MINIMUM ($175,000).
- $300,000 IS PROTECTED

University of Maryland Center on Aging

Partnership for Long-Term Care

UMCA

Fact Sheet

University of Maryland, National Program Office
Mark R. Meiners, Ph.D., Director

The Partnership for Long Term Care provides an alternative to spending down or transferring assets by forming a partnership between Medicaid and private long term care insurers.

Partnership states have focused on creating affordable products that encourage people to self-insure, enable purchasers to provide better protection against impoverishment, and reduce long term care costs for the Medicaid program.

By design, the Partnership policies are Medicaid budget neutral. While states must forgive part of the insured's potential spend-down, the insurance company is absorbing costs for long-term care that would have been Medicaid's responsibility. The extremely small number of policy-holders who have actually accessed Medicaid (<50) illustrates the effectiveness of the Partnership in meeting the budget neutrality goal.

Policy Types

Dollar-for-Dollar Model (CT and CA)

- Policies must cover at least one year at issue and pay a minimum daily benefit (determined by each state)
- Once policy benefits are exhausted, every dollar paid out by the insurer will be deducted from resources counted for Medicaid eligibility

Total Assets Model (NY)

- Policies must cover three years of nursing home care, six years of home care or a combination of the two
- Once policy benefits are exhausted, protection is granted for all assets, but an individuals income must be devoted to the cost of care

Hybrid Model (IN)

- Policies must cover at least one year at issue and pay a minimum daily benefit
- The value of coverage purchased and later used, determines the method used for determining asset protection in Medicaid eligibility
- If the amount purchased is equal to or above the state-set amount for the policy effective year, total asset protection is applied
- If the amount purchased is less than the state-set amount, the dollar-for-dollar method is

used
- Regardless of which method is used, an individual's income must be used for costs of care

Current State Data

	California (through 1Q 2003)	Connecticut (through 2Q 2003)	Indiana (through 2Q 2003)	New York (through 4Q 2002)	Four State Total
Total Applications Received:	**61,954**	**37,274**	**32,629**	**65,987**	**197,844**
Applications Denied:	11,192	4,370	4,329	10,595	30,486
Applications Pending & Withdrawn:	0	2,081	696	6,204	8,981
Total Policies Purchased:	**50,762**	**30,823**	**27,604**	**49,188**	**158,377**
Policies Dropped:*	4,547	2,918	2,680	4,728	14,873
Policies Not Taken Up:	2,232	2,376	2,155	4,994	11,757
Total Policies In Force (active):	**43,947**	**25,188**	**23,294**	**38,562**	**130,991**
Policyholders Who Received Service Payments:	512	216	145	720	1,593

* Does not include drops reported as deaths, rescissions or exhausted benefits.

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Last Updated 10/14/03

University of Maryland Center on Aging

Partnership for Long-Term Care

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University of Maryland Center on Aging

Partnership for Long-Term Care

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OBRA 1993 Provisions Pertaining to The Partnership For Long-Term Care

The Omnibus Reconciliation Act of 1993 contained language with direct impact on the expansion of partnerships for long-term care. The Act recognized the four initial states now operating partnership programs plus a future program in Iowa and a modified program in Massachusetts. These six states were allowed to operate their partnerships as planned because their state plan amendments were approved by HHS before May 14, 1993.

States seeking a state plan amendment after May 14th must abide by the conditions outlined in OBRA'93. There are three sections with specific language pertaining to partnership programs. The following outlines the requirements in each section.

- **Sec 1917(b) paragraph 1 subparagraph C**
  This section requires any state operating a partnership program to recover from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the partnership is in effect only while the insured is alive. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets.

- **Sec 1917(b) paragraph 3**
  This section prevents a state from waiving the estate recovery requirement for partnership participants.

- **Sec 1917(b) paragraph 4 subparagraph B**
  This section requires a specific definition of "estate" for partnership participants. Estates:

  A. shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

  B. . . . any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other assignment.

The above definition may vary from the current definition used by a state for estate recovery. States implementing a partnership may find themselves in the position of having to use a more encompassing definition for partnership participants alone. These post OBRA partnership states may even have to seek legislative approval to implement the required recovery process for partnership participants.

To amend title XIX of the Social Security Act to permit additional States to enter into long-term care partnerships under the Medicaid Program in order to promote the use of long-term... (Introduced in House)

HR 1406 IH

108th CONGRESS

1st Session

H. R. 1406

To amend title XIX of the Social Security Act to permit additional States to enter into long-term care partnerships under the Medicaid Program in order to promote the use of long-term care insurance.

IN THE HOUSE OF REPRESENTATIVES

March 20, 2003

Mr. PETERSON of Pennsylvania (for himself, Mr. POMEROY, Mr. PLATTS, Ms. HART, Mrs. JOHNSON of Connecticut, Mr. BISHOP of Utah, Mrs. NORTHUP, Mr. MURPHY, Mr. GERLACH, Mr. SHUSTER, Mrs. EMERSON, Mr. ENGLISH, Mr. TOOMEY, Mrs. CAPITO, Mr. GREENWOOD, Mr. HOEFFEL, Mr. CARDIN, and Mr. MURTHA) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend title XIX of the Social Security Act to permit additional States to enter into long-term care partnerships under the Medicaid Program in order to promote the use of long-term care insurance.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PERMITTING ADDITIONAL STATES TO ENTER INTO LONG-TERM CARE PARTNERSHIPS TO PROMOTE USE OF LONG-TERM CARE INSURANCE.

(a) IN GENERAL- Section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) is amended--

(1) in clause (i), by striking `shall seek adjustment' and inserting `may seek adjustment'; and

(2) in clause (ii), by striking `had a State plan amendment approved as of May 14, 1993, which provided' and inserting `has a State plan amendment approved which provides'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) take effect on the date of the enactment of this Act.

What is the California Partnership for Long-Term Care?

The California Partnership for Long-Term Care is an innovative program of the State of California, Department of Health Services in cooperation with a select number of private insurance companies. These companies have agreed to offer high quality policies that must meet stringent requirements set by the Partnership and the State of California. These special policies are commonly called "Partnership policies".

The Partnership's mission is to provide Californians like you with affordable, quality long-term care insurance protection, so you will not be forced to spend everything you have worked for on long-term care. Additionally, the Partnership seeks to protect you from having to spend down your assets, should you use up your private long-term care benefits and need to apply for Medi-Cal assistance. Finally, the Partnership seeks to protect your assets from Medi-Cal estate recovery.

Nursing home care in
California averages about $150
a day or nearly $55,000 in 2003

The Connecticut PARTNERSHIP FOR LONG-TERM CARE

General Information

The Connecticut Partnership for Long-Term Care is a program of the State of Connecticut that works in alliance with the private insurance industry. It is a joint effort by State government and private industry to create an option to help you plan to meet your future long-term care needs without depleting all of your assets to pay for care.

Under the Connecticut Partnership, private insurance companies competitively sell special long-term care insurance policies. These policies not only offer benefits to pay for long-term care costs, they also offer Medicaid Asset Protection should you ever need to apply to Connecticut's Medicaid Program for assistance.

For most people, it is unpleasant to think about needing nursing home or home care when they get older. No one is immune to this possibility. Even more unpleasant is the likelihood that you will have to sacrifice your life's savings to pay for that care – if you don't plan ahead.

To help you plan for your financial future, the State of Connecticut has joined forces with private insurance companies to form the Connecticut Partnership for Long-Term Care.

David J. Guttchen

Special Reports...

Annual Report - most recent report to the Connecticut General Assembly

Annual Evaluation Studies - results and analysis from management and evaluation surveys

Benefits...

Working together, this public/private partnership has created an innovative program that offers you:

- quality, affordable long-term care insurance; and

- a way to get the care you need without depleting all of your assets.

The Connecticut Partnership's website is designed to help you learn more about how planning now can help guarantee a secure tomorrow.

For more information contact:
David **Guttchen**, Director
David.Guttchen@po.state.ct.us; (860) 418-6318

About the NYSPLTC

The New York State Partnership for Long-Term Care (the Partnership) is a unique and innovative program that combines private long-term care insurance and Medicaid to help New Yorkers prepare financially for the possibility of needing nursing home or home care. The program allows New Yorkers to protect their assets while remaining eligible for Medicaid if their long-term care needs exceed the period covered by their private insurance policy.

- **SAY THAT AGAIN?**
  If you buy a long-term care insurance policy under the Partnership program, and you use 3 years of nursing home care, or 6 years of home care, or some combination of the two, you may apply for New York State Medicaid benefits AND STILL RETAIN ALL YOUR ASSETS. You will, however, have to contribute your income to the cost of your long-term care.

- **WHY WAS THE PARTNERSHIP CREATED?**
  The Partnership was created to help New Yorkers finance long-term care without impoverishing themselves or signing over their life's savings, with the accompanying loss of dignity. In the long run, the program will help reduce New York's massive Medicaid tax expenditure - over $7 billion in 1998 and growing. The Partnership offers New Yorkers and New York a better alternative.

- **WHAT ARE THE BASIC BENEFITS?**
  All participating insurance companies are required to offer a **basic policy** which contains the following minimum benefits:
  - Coverage for at least 3 years of nursing home care, 6 years of home care or a combination of the two (where 2 home care days equal 1 nursing home day).
  - $163/day coverage for nursing home care; $82/day coverage for home care in 2003.
  - Inflation protection equal to 5% compounded annually.
  - Care management: information, referrals, consultation on service needs and benefits.
  - 14 days of respite care, renewable annually, to give the at-home caregiver some needed rest.
  - 30 extra grace days to pay the premium IF you have designated someone to be notified if you don't pay your premium on time.
  - Special consideration for adjustment of premiums/benefits in the event of a national long-term care program.
  - Review of denied requests for benefit authorization on a case-by-case basis.

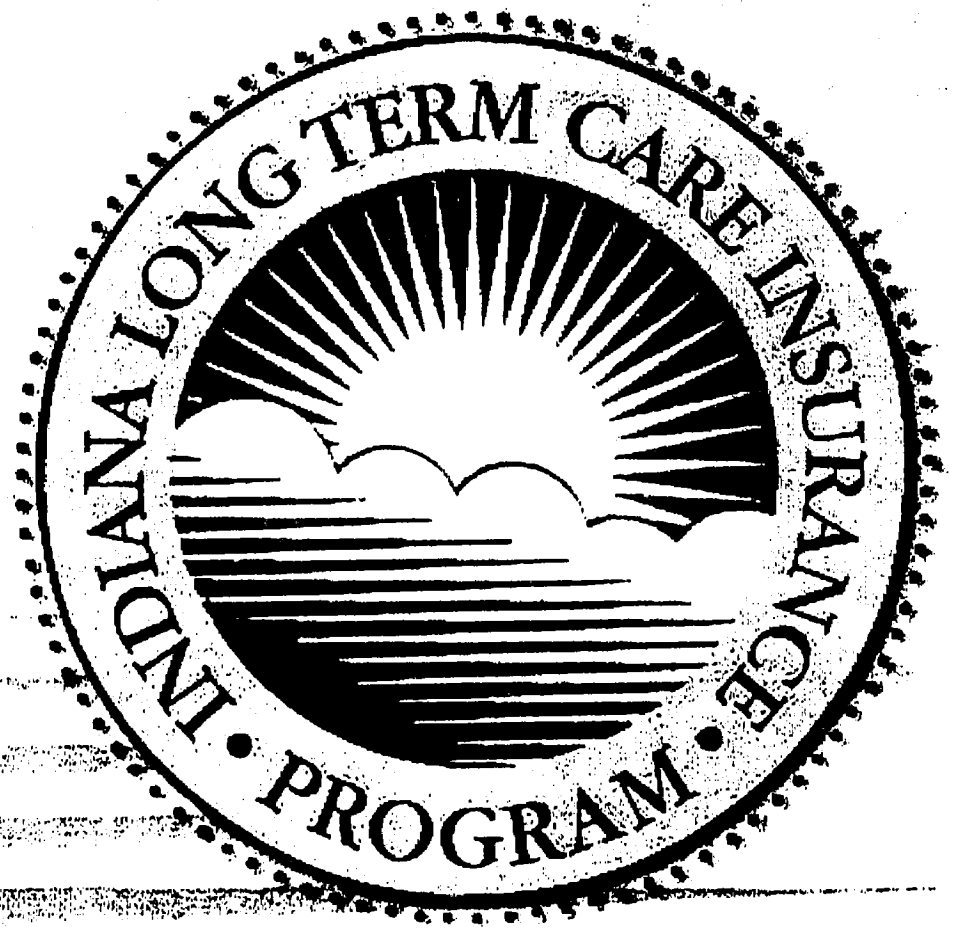
  You can also select richer policy benefits. However, all Partnership policies have, at least, the above-listed basic benefits.

- **WHY SHOULD I CONSIDER A POLICY?**
  - To stay in control of your own assets.
  - To increase your chance of getting the long-term care of your choice -- whether in a nursing home or in your home -- when you need it.
  - To continue to feel like a dignified, independent human being.

  More than 2 out of 5 Americans 65 and over face going into a nursing home at some point in their remaining lifetimes. Think about it.

Who Is The Partnership For

While the policies are not a solution for everyone, they may be for you. The state recommends



Retire with Confidence

The Need for Long Term Care

- One of two women and one of three men who reach the age of 65 will use a nursing home at some point during their lives.
- 40% of nursing home residents are between 18 and 64 years of age.
- Seven in ten individuals will need home health care.

The Cost of Long Term Care

- In 2002, the average cost of nursing home care in Indiana was $121 per day or $44,165 per year.
- The cost for a home health aide to provide assistance for eight hours a day, five days a week, for a year, is more than $15,000.
- Care in an assisted living facility averages $1,800 to $2,000 per month.

Long term care is expensive!

Who pays for Long Term Care

- Medicare: Nationally, pays for less than 5% of nursing home costs.
- Private-Pay: 32% of long term care costs are paid by private-pay means.
- Medicaid: Pays for approximately 63% of all long term care costs. (After nearly all assets are gone.)

Indiana Long Term Care Insurance Program

- The ILTCIP or "Indiana Partnership Program" pairs State government with private long term care insurance companies and their agents.
- Provides high quality long term care insurance containing consumer protection features and Medicaid Asset Protection, a unique State-added benefit.
- Indiana is one of only four states to have developed such a program.

Medicaid Asset Protection

A free benefit found only in Partnership policies!

Policyholders protect assets by purchasing and using their Indiana Partnership policies.

- Assets will not be counted during the Medicaid eligibility process.

- Assets will be not be included in the Medicaid estate recovery process.

Medicaid Asset Protection

Dollar-For-Dollar Asset Protection

- Individuals who purchase an Indiana Partnership policy with initial coverage of less than the State-set dollar amount for that year will receive dollar-for-dollar asset protection.
- They will earn $1 of asset protection for every $1 of benefits paid out by the policy.

Medicaid Asset Protection

Total Asset Protection

- Individuals who purchase an Indiana Partnership policy with minimum coverage of the State-set dollar amount ($178,679 for 2003), then exhaust their policy benefits and apply for Medicaid assistance will receive a total asset disregard.

Other Partnership Policy Features

- **Indiana Residents**
  Indiana Partnership policies may only be sold to Indiana residents. However, insurance policy benefits will be paid regardless of the state in which the policyholder is receiving care.

The exception is the Medicaid Asset Protection feature.

Other Partnership Policy Features

- **Two Policy Types**

➢ All participating insurance companies must offer a "comprehensive" policy containing nursing home and home & community-based benefits.

➢ Insurance companies may choose to offer a "long term care facility" policy. This type of policy provides coverage primarily for institutional care.

There are also federally tax-qualified versions of both policy types available.

Medicaid Asset Protection

Win-Win-Win

- Medicaid Asset Protection is the State's way of saying "thanks for using a high quality long term care insurance product before turning to Medicaid for assistance."
- Another "win" for the policyholder is that premiums paid for an Indiana Partnership policy may be deducted on an Indiana tax return.

Other Partnership Policy Features

- **Inflation Protection Feature**

➢ All Indiana Partnership policies contain an inflation protection feature.

➢ With the inflation protection feature, both the daily benefit and the maximum benefit within the policy increase annually at a 5% compounded rate.

Other Partnership Policy Features

- **Benefit Triggers**

➢ In Indiana Partnership policies, participating companies must use the benefit triggers and definitions selected by the State.

➢ With all Partnership policies paying out benefits for the same event, it makes it easier for the consumer to comparison shop.

Other Partnership Policy Features

- **Identification**

To identify an Indiana Partnership policy, look for the following box of information on the application, the outline of coverage, or on the front page of the policy:

> THIS POLICY QUALIFIES UNDER THE INDIANA LONG TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE INSURANCE PROGRAM.

Indiana Partnership Companies and Agents

- Any company can participate as long as it obtains approval from the Indiana Department of Insurance for a policy that meets the Indiana Partnership standards.

- All participating companies offer both traditional long term care insurance policies and Indiana Partnership policies.

- Before an agent can market an Indiana Partnership policy, he/she must have first completed a 7-hour course about the Indiana Partnership Program.

Indiana Partnership Statistics

(through June 2003)

- Sales
  - 32,629 applications received
  - 27,604 policies purchased
  - 23,294 policies in force

- Purchasers
  - 57% female
  - 76% married
  - 93% first time buyer
  - Average age: 62
  - Age range: 19—90

Indiana Partnership Statistics

Policy Features

- 85% of policies purchased include home health care
- 74% of policies qualify for total asset protection
- Common daily benefits chosen: $120 nursing home; $120 home health
- Common elimination periods chosen: 30, 90, or 100 days

Indiana Partnership Statistics

Benefits Used

- 145 policyholders have used benefits
- 66% of benefits used have been for NH care
- 8 have exhausted their policy benefits and are receiving Medicaid assistance without having to spend down their assets

To Learn More:

- Call toll-free 1-866-234-4582 for a free information packet on Indiana Partnership policies.
- Visit www.longtermcareinsurance.IN.gov.
- For specific company or policy information, schedule an appointment with an Indiana Partnership certified agent.